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References: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (2) Goslings, W. R. O., & Büchli, K.: *Arch. Int. Med.* 102:691, 1958. (3) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (4) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (5) Petersdorf, R. G., et al.: *Arch. Int. Med.* 105:398, 1960. (6) Glas, W. W., in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Modarress, Y.; Ryan, R. J., & Francis, Sr. C. E.: *J. M. Soc. New Jersey* 57:168, 1960. (8) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960.

IN VITRO SENSITIVITY OF COAGULASE-POSITIVE STAPHYLOCOCCI TO CHLOROMYCETIN FROM 1955 TO 1959*



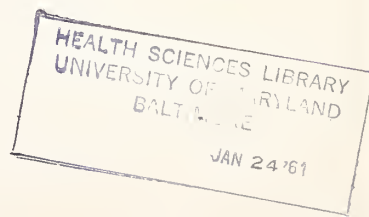
These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, Perry, & Kirby¹

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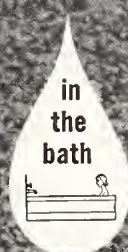
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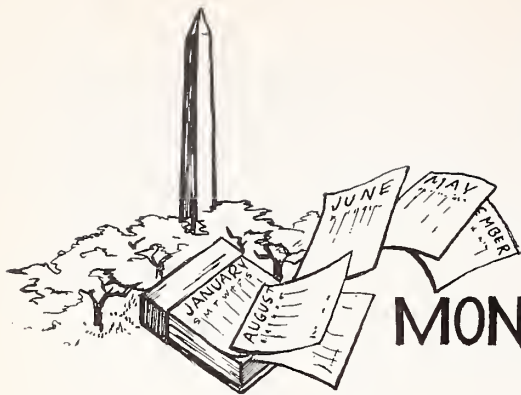
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1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—Physicians are being urged to cooperate fully to get their states to participate as soon as possible in the new federal-state program for medical care of needy and the near-needy older persons.

The medical profession also has been alerted to the dangers of relaxing its opposition to tying in medical care of the aged with Social Security. It is probable that the Kennedy Administration will try in 1961 to get Congressional approval of such legislation.

E. Vincent Askey, M.D., President of the American Medical Association, pointed out to the recent Washington meeting of the AMA House of Delegates that proponents of the Social Security approach had a pledge of support from the successful Democratic candidate for President.

"While our profession clearly may face a hard struggle in the 87th Congress on the issue of medical aid for the aged under Social Security, there is no ground for defeatism!" Dr. Askey said.

"Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained."

Dr. Askey reminded the House of Delegates that "medicine has many friends in both parties in Congress today."

A few days later, Sen. Harry F. Byrd (D., Va.), chairman of the Senate finance committee which handles Social Security legislation, reiterated his opposition to a compulsory medical care plan under Social Security. He said:

"I am opposed to the (Democratic party) platform recommendation for compulsory medical service and hospitalization under the Social Security system. I am convinced this would lead to socialized medicine with the possibility that it would bankrupt the Social Security trust fund. This matter came before the finance committee and was fought out in the post-convention session of Congress last August. The Senate voted 51 to 44 in opposition to the Democratic platform proposal, and instead adopted a fair plan for medical service and hospitalization for those in need of it."

Continued



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DR. ASKEY URGES MEDICAL LEADERSHIP

Dr. Askey urged that all county and state medical associations provide "the medical leadership necessary to implement the Mills-Kerr bill (the new federal-state program) as rapidly as possible." And the House of Delegates adopted such a resolution.

"We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, practically as well as potentially, solve the problem of medical care for the aged," Dr. Askey said.

President-elect John F. Kennedy's first Cabinet appointment was Gov. Abraham Ribicoff of Connecticut as Secretary of Health, Education and Welfare—the official with primary responsibility for carrying out the federal part of the Mills-Kerr program.

Ribicoff, 50, was an early supporter of Kennedy for the Presidential nomination. He was twice elected governor of Connecticut. Before that, he served as a Hartford, Conn., police judge, a member of the state legislature and a member of the national House of Representatives. As governor, he inaugurated a comprehensive traffic safety program with strong penalties.

SABIN VACCINE PROBLEMS NOT SOLVED

The Sabin oral polio vaccine will not be available in sufficient quantity in 1961 for large scale use.

Leroy E. Burney, M.D., Surgeon General of the U.S. Public Health Service, told the recent Clinical Meeting of the AMA that many problems involving in taking the oral vaccine out of the laboratory and into mass production had not been solved.

In light of this fact, both the AMA House of Delegates and Dr. Burney urged that the widest possible use of the Salk vaccine be encouraged. Dr. Burney said that large numbers of the U. S. population, including almost half of the children under five, had not been fully vaccinated with the effective Salk vaccine.

Dr. Burney said the problems of integrating the oral vaccine into the present program of immunization against polio "are many and complex."

"Only the future can tell whether control of poliomyelitis will be accomplished through a live, orally administered vaccine, the killed vaccine, or a combination of both," Dr. Burney said.

FLUNKING FOREIGN INTERNS CAN REMAIN LONGER

Foreign interns who failed medical examinations last September may remain in this country until at least next July 1.

In cooperation with the State Department, the AMA agreed to extend for six months a Jan. 1 deadline for dismissal of foreign interns unless they pass the examinations through the Educational Council for Foreign Medical Graduates.

MONTH IN WASHINGTON

The flunking interns will be given another opportunity to take the examinations in April. Meantime, they must be taken off patient care and their hospitals must set up training programs for them.

The AMA Council on Medical Education and Hospitals, said that this policy would be carried out judiciously and that occasional exceptions would be granted where circumstances warranted.

STRICTER DRUG RULES

The Food and Drug Administration issued stricter rules, some effective Jan. 8 and others effective March 9, governing promotion and marketing of prescription drugs. The new regulations are designed to insure safe use of the drugs.

Under the new regulations, manufacturers must disclose hazards, as well as advantages, of the drugs in promotional material sent to physicians. Manufacturers can be denied permission to market drugs they refuse to permit FDA inspection of manufacturing methods, facilities, controls or records.

The FDA deferred until later action on its proposal to require every package of drugs sold to pharmacies to contain an official brochure on their use and hazards. The AMA proposed instead that it be given the responsibility of getting such information directly to physicians. ◀

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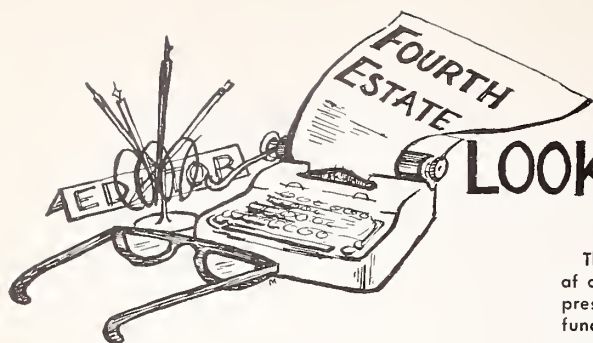
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

It Was Good News

The fact that Eli Lilly & Co. has earned profits averaging 11.2% over the last 10 years is the best news to come out of a congressional investigation in some time. This means that the Indianapolis pharmaceutical firm is a sound, growing organization that makes a solid contribution to the economic stability of the community and to the state.

These figures were made public by Eugene N. Beesley, Lilly's president, when he appeared in Washington before Senate investigators.

Beyond that, the Senate subcommittee did little but confirm the community opinion of Lilly's reputation as a business which had developed into a giant because it was aware of its responsibilities to the public. The Lilly record in the production of anti-polio vaccine is a case in point.

There are times when the ardor of congressional investigators outruns good judgment. Hauling Eli Lilly & Co. up to explain why it is a successful business was more a matter of zeal than of mature deliberation.

Indianapolis will be encouraged to hear about the good business health of this local firm. Hoosiers can be proud of the record of this company under the free enterprise system.

Indianapolis Star
Sept. 19, 1960

For the Last, Best Years

Early in January several thousand persons will gather in Washington for a White House Conference on Aging. They will devote four days of discussions to questions of the living conditions, the care and the opportunities for the nation's growing group of "senior citizens."

This is a field which has occupied a great deal of public attention in recent years. An indication of its prominence may be found in the fact that it figured substantially in the presidential election campaign just ended.

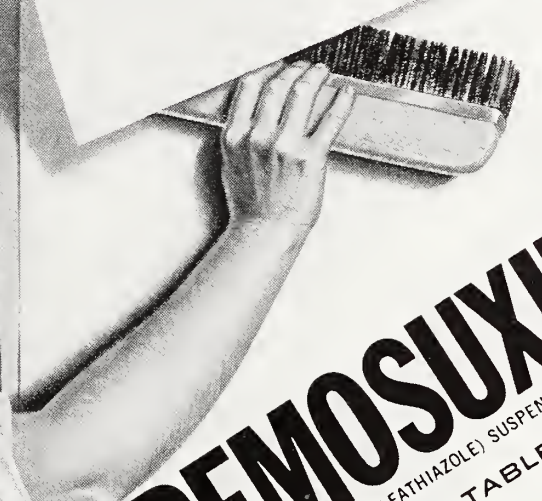
There is a double reason. The proportion of elderly persons in the population is becoming larger, and they are living longer. The numbers of persons who retire from their normal occupations, voluntarily or otherwise, are also becoming larger, so that there is a growth in the proportion of elderly persons who have time on their hands.

Under the circumstances, a great many persons will be looking with high hopes toward this White House Conference. Their hopes deserve fulfillment. We hope and trust they will fare better—much better—than those who have looked with similar hopes on other White House Conferences.

Last spring's White House Conference on Youth, by way of illustration, was heavily loaded with persons who would carry its deliberations in a single general direction—toward recommendation of new and expanded Federal activity in all phases of the subject which were to be considered. This was done through direct selection of the speakers, the leaders and a substantial number of the participants.

The major speakers said their pieces and left. There was no opportunity for the conference participants to question them from the floor, or otherwise to suggest lines of inquiry for the formal presentation sessions which occupied more than half of the total conference time. In these clock-ridden, one-way sessions there was a tremendous waste of the talents of some of the country's most eminent authorities in the field

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of youth problems and activities. There was a deep and tragic frustration for concerned persons from all over the country who were eager to match ideas and experiences with these great leaders.

In the rest of the sessions the participants for the most part found themselves either caught up in discussion of a narrow and sharply limited field which was not of special interest to them, discussions which as far as they were concerned were not going anywhere important, or else sitting in the midst of skillfully fashioned machinery smoothly moving toward recommendations which could readily be foreseen on the opening day. The formulation of the conference recommendations was, from beginning to end, firmly in the hands of the selected leadership. Those participants who wanted to go in other directions were reduced to formulating innocuous propositions or fighting to salvage something of their ideas and principles by changing a word or a phrase here and there in the recommendations predestined to emerge.

It was an operation which left countless participants disappointed, disillusioned and grumbling. Many persons of real talent and experience had prepared for months for the opportunity to present their ideas in this great gathering, only to find that their ideas were not wanted.

There was so much grumbling, in fact, that the conference report was utterly undermined before it even was gathered together, and the impact of the conference has been virtually lost.

We earnestly hope that a lesson has been learned, that this Conference on Aging will be different. We hope it will be free from the ineptly concealed pulling of strings. We hope it will be an earnest and open-minded search for new ideas and unvarnished facts. We hope those who go will have the satisfaction of finding themselves really part of such a search, and that they will come away with a sense of having really helped individually to set in movement forces and ideas which can make life better for those who are older.

Indianapolis Star
Dec. 5, 1960

Revise Or Repeal

The whole United States has a confused medical care bill because Indiana's Attorney General failed to warn all senators and congressmen.

This appears to be the burden of a doleful tune sung out of Washington over the weekend by Representative Joe Barr, the Democrat who speaks for Indianapolis and Marion County in Congress. As excuses go, this is a feeble one.

Barr complains that Attorney General Edwin K. Steers wrote a lot of letters on many subjects, but failed to "jog" the Indiana delegation on secrecy provisions of the new medical-aid-for-the-aged law adopted by Congress. Steers should have known Congress was writing a bad law, Barr says by indirection. Knowing that, Steers should have warned all Indiana members of Congress about this undesirable legislation.

The facts are not nearly so involved. Congress met in an air of undignified hurry after the political conventions to write what the Democrats hoped would be a campaign program. The medical care plan was one of the "must" items shoved into the hopper by the liberal Democrats. Time began to run out, and some kind of law had to be passed.

The Democrats who controlled Congress and its committees produced this law. It was supported in final form by both Democrats and Republicans, and was signed by President Eisenhower. Confusion has reigned about the statute and its provisions ever since.

This program is a fair sample of the Kennedy-Johnson leadership, a fact which will weigh heavily in the minds of Hoosier voters in November. Barr's vote for the law was a bad one. He can hardly push the blame off on the state legal officer when Steers has neither the responsibility nor right to cast a ballot in Congress.

Viewed from almost any angle, the medical care for the aged law is a thoroughly botched up piece of legislation. It does nothing for Indiana that Indiana hasn't been doing for itself and its citizens over a period of 13 years.

Congress needs to revise drastically or repeal totally this poor law.

Indianapolis Star
Sept. 21, 1960

*The following five papers
were among those read at the
June 17 meeting of the
Kentucky and Indiana Chapters
of the American College of
Surgeons at French Lick, Indiana.*

Hemorrhoidectomy

*JAMES M. McINTYRE, M.D.
Indianapolis*

INDICATIONS FOR hemorrhoidectomy include protrusion, bleeding, anorectal pain and at times, perianal itching not relieved by conservative treatment. Examination should reveal hemorrhoidal disease to be severe enough to cause the symptoms and justify surgery. Needless to say, all patients requiring anorectal surgery should have sigmoidoscopy, and some should have colon x-rays to rule out the presence of carcinoma or ulcerative colitis. Anorectal surgery, performed in the presence of active ulcerative colitis, except for incision and drainage of abscesses, may be more detrimental than beneficial.

There are numerous methods for performing hemorrhoidectomy; namely, clamp and cautery, ligature and excision with or without the use of a hemorrhoid clamp and amputative and plastic procedures. My preference at the present time is the ligature and excision technic without using a hemorrhoid clamp and at times combined with a sliding skin graft.¹

Preoperative Preparation

Patients are hospitalized the day before surgery and the usual laboratory tests performed.

A Fleet's enema is given the evening before, and repeated at 6:00 a.m. the day of surgery. The buttocks are shaved and scrubbed with soap and water. Proper preanesthetic medication is prescribed by the anesthesiologist. Sterilization of the bowel preparatory to anorectal surgery is seldom necessary.

Anesthesia

Spinal, caudal, general or local anesthesia are all satisfactory. However, I prefer local anesthesia supplemented by only enough intravenous sodium pentothal to keep the patient comfortable and quiet. Most of the usual local anesthetic solutions may be used if one is careful to adjust dosage to toxicity. A solution of pontocaine .075%, xylocaine 0.5% with adrenalin 1-200,000 and hyaluronidase (Wydase) 150 units is satisfactory from the standpoint of low toxicity, rapid onset and prolonged duration;² satisfactory anesthesia is produced by 35 to 40 cu cm of the solution. Local anesthesia^{3, 4} produces better relaxation of the anal canal than other forms of anesthesia. Manual dilatation or forcible retraction of the anus is unnecessary while post-operative pain and urinary complications are diminished.

Operative Technic

The patient is placed in the prone position with a blanket roll under the pelvis. Buttocks are separated by adhesive straps applied to each side of the gluteal fold and secured to the operating table. The skin is scrubbed with soap and water, and an intravenous solution of sodium chloride and sodium pentothal is started by the anesthesiologist. Local anesthetic is administered by first making a small skin wheal midway between the anus and the coccyx, with a No. 25 gauge needle and continuing the injection with a No. 22 gauge 1.5 inch needle in a diamond-shaped fashion around the anus; injecting subcutaneously 20 cubic centimeters of the anesthetic solution. Then by injection, just distal to the anal verge in each lateral quadrant, five cu cm of the solution is introduced in a fan-shaped fashion beneath the skin of the anal canal. Finally, a small Sims vaginal retractor is introduced and two cu cm of solution are injected submucosally in the anterior, posterior, right lateral and left lateral quadrants, the needle being inserted just distal to the pectinate line. Relaxation of the anal sphincter occurs almost immediately following injection of the anesthetic solution, and there is no distortion of the tissues.

The hemorrhoid to be excised is visualized with a Sims vaginal retractor. Longitudinal skin incisions are made on either side of the external hemorrhoid and united laterally in the perianal region. The external hemorrhoid is grasped with an Allis forcep and dissected away from the fibers of the external and internal sphincter muscles. The dissection is continued to include the proximal portion of the internal hemorrhoid, and a ligature of chromic 0 catgut suture is placed through and tied around the pedicle. The tissue distal to the ligature is excised, and the mucosal edge is attached to the sphincter muscle at the pectinate level with a few interrupted sutures of chromic 000 catgut.

This maneuver controls bleeding from the mucosal edge and also stabilizes the mucosa thus tending to prevent a subsequent prolapse of mucosa which sometimes follows the ligature and excision method of hemorrhoidectomy. The hemorrhoidal excisions are routinely performed in the anterior, right lateral and left lateral quadrants, and small areas of muco-cutaneous tissue are preserved between the excisions.

When a hemorrhoid, fissure or papilla is present in the posterior quadrant, the pathology is

excised and the wound repaired with a sliding skin graft;¹ for a scar in the posterior quadrant more frequently heals poorly or forms a fissure, necessitating further surgery. In such instances a transverse incision is made at the anal verge to include all the skin remaining in the posterior quadrant. The hemorrhoidal tissue or fissure is dissected free from the fibers of the sphincter muscle and excised transversely by an incision through the mucosa proximal to the internal hemorrhoid. The skin distal to the transverse anal incision is mobilized enough to allow its approximation to the pectinate level by undercutting, and incisions on each lateral border are directed posteriorly and laterally for a distance of one to two inches.

If the anus is stenosed, a portion of the scar and sphincter muscle in the posterior quadrant is incised or excised to allow the introduction, without tension, of the operator's two fingers. The skin is then sutured to the rectal mucosa at the level of the normally placed pectinate line with interrupted chromic 000 catgut suture. The bleeding vessels in the external wounds are ligated with plain 000 catgut sutures. Small pieces of oxycel gauze are placed in the open wounds, and a Penrose drain is inserted into the rectum. A pressure dressing is applied to the anal region and the buttocks are strapped together with adhesive tape.

Postoperative Care

Morphine gr. 1/6 or gr. 1/4 depending on the weight of the patient is given hypodermically for pain, as necessary. A low roughage diet is ordered the day of surgery, and catheterization specified every eight to 12 hours.

When patients are catheterized, Gantrisin gr. 7.7 is administered three times daily for 48 hours. Sitz baths are allowed twice daily. A hydrophyllic drug is administered twice daily, and full ambulation is encouraged starting on the first postoperative day. Morphine is usually unnecessary after the day of surgery, as the discomfort can be controlled with Darvon Compound, one capsule every three hours, and hot moist packs every four hours.

If the bowels have not moved by the morning of the third postoperative day, a Petrogalar enema is administered through a No. 22 French catheter, and repeated every other day if necessary.

Digital examination, using the fifth finger lubricated with polycin ointment, is performed daily beginning the fourth postoperative day, and digital examination using the index finger is performed a day or two before the patient leaves the hospital. The patient, when dismissed from the hospital, is instructed to dilate the anus daily, using the well lubricated gloved index finger, and is examined at frequent intervals until a satisfactory result has been achieved.

Complications

Hemorrhage: Bleeding which occurs in the first 24 hours after surgery is usually caused by a bleeding vessel in the external wound, and is controlled by a pressure dressing or a ligature. Secondary hemorrhage occurring in .5 to one percent of patients usually seven to 10 days after surgery is more commonly caused by bleeding from the internal hemorrhoidal ligature. If such bleeding is minimal, bed rest is satisfactory treatment; however, when the bleeding is moderate or severe the patient should be anesthetized, the rectum examined and the bleeding vessel ligated. Rarely severe bleeding will cease spontaneously; so if no bleeding vessel is identified after removal of the clotted blood by saline irrigation, strips of oxycel gauze are inserted in the anus and a pressure dressing is applied.

Abscesses: Occasionally abscesses or sinuses occur from bridging of the skin edges, and they are treated by incision and excision of the overhanging skin edges.

Urinary retention: Approximately two to five percent of the patients have sufficient urinary difficulty to require an indwelling catheter, and

in this group some male patients will require resection for prostatic obstruction.

Fecal Impactions: The incidence of fecal impaction is not frequent; however, many patients have difficulty passing satisfactory stools for a short period of time following anorectal surgery. At times enemas of mineral oil, ounces 1½, Pectogal and water or equal parts of milk and molasses are necessary to prevent or relieve fecal impactions.

Contractures: A variable degree of anal stenosis occurs about three to four weeks after surgery. Daily digital dilatation by the patient, periodic dilatation by the surgeon and time allowed for the scar to become pliable will give satisfactory results in most instances; however, additional surgery may infrequently be necessary to correct a severe anal contracture.

Summary

The technique of hemorrhoidectomy and local anesthesia has been discussed. The management of after-care and some of the complications have been outlined.

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Early diagnosis may make embolectomy and preservation of intestine possible.

Mesenteric Arterial Occlusion

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THE INTESTINE IS SUBJECT to the same occlusive vascular disorders as the lower extremities. The more common of these are sudden occlusion by an embolus or thrombosis and varying degrees of ischemia secondary to narrowing of the major arteries by arteriosclerosis. Other types of arterial disease occur, but are rare. During recent years considerable improvement has been made in the treatment of these conditions in the extremities.

Formerly, amputation was the only recourse available; now, embolectomy, thromboendarterectomy, bypass grafting and sympathetic denervation have a place in our armamentarium. Corresponding progress, quantitatively at least, has not been evident in the treatment of the same disorders of the splanchnic circulation.

Still in Amputation Era

Although it has been demonstrated that each of these operations is applicable, for the most part we are still in the era of amputation. The explanation for this is obvious. Compared to those of the intestine, ischemic disorders of the extremities, either acute or chronic, present better localized and more easily demonstrated and assessed signs and symptoms. This, plus their greater frequency, has resulted in greater familiarity and—most important—earlier diagnosis. Also, a delay of eight hours or so between the onset and treatment of an acute arterial obstruction of the extremity is often compatible with a

successful surgical restoration of circulation. However, due to the greater sensitivity to hypoxia and the bacterial content of the intestine, relatively brief periods of arterial occlusion lead to irreversible changes affecting not only the life of the organ but also that of the individual.

During the past seven years, diagnosis of mesenteric arterial disease was made by operation or autopsy in 15 patients at the Indianapolis Veterans Administration Hospital. Twelve patients had acute occlusions with infarcted intestine at the time of diagnosis and three had chronic obstructions producing the syndrome of intermittent intestinal claudication or intestinal angina. Results of treatment were poor (Table I). Among the 12 patients who had infarctions of the intestine from thrombosis, embolism or arteriosclerosis obliterans, only two survived. One died in three years of a cardiac arrhythmia and the other is now living six months postoperatively. Both of these patients were treated by resection of the ischemic bowel. Poor as these results are, they are consistent with other reported experience. Ficarra⁴ found that of 554 cases of massive infarction reported by 1944, resection had been successful in only 32, or six percent.

Often Become Nutritional Cripples

Even if survival is achieved with resection the patient often becomes a nutritional cripple. Morbidity increases directly with the amount of small intestine removed in excess of 50%. Resection of more than 80% is rarely compatible with life.

*Chief, Surgical Service, Veterans Administration Hospital; Assistant Professor of Surgery, Indiana University School of Medicine.

Treatment and Survival

Mesenteric Diagnosis	No. of Patients	Unoperated	Exploration Only	Resection	Vascular Procedure
Infarcted Embolus	6	1d, 2d	5d	12d, 3 yr. living 6 mos.	
Thrombosis	3	3d	1d		1d
A.S.O.	3	3d, 4d		2d	
Non-infarcted "Angina"	3		1d, 4d, 14 mos.		

TABLE I

Recently some success has been attained in attempts to restore the acutely occluded splanchnic circulation. Superior mesenteric artery embolectomy has been reported in 12 patients. In six of these circulation was re-established, but death occurred in the early postoperative period from cardiac decompensation⁶ and from infarction¹⁰ in two cases each, from other emboli¹⁰ and intra-peritoneal hemorrhage⁶ in one case each. One embolectomy failed, but the patient survived following resection.⁷ In the remaining five patients the operation was successful.^{5, 7, 10, 12} Also, three patients with thrombosis of the superior mesenteric artery have had effective thromboendarterectomies.^{5, 9}

One patient in the present series had thromboendarterectomy performed. Blood flow was easily restored in the major artery but irreversible changes had occurred in the bowel and the patient died the next day.

Attempt When Possible

These procedures certainly should be attempted whenever possible in the patient who has an acute infarction. If successful in reviving any or all of the ischemic intestine the result will be superior to that obtainable by simple resection. However, it is not yet determined that the percentage of patients saved would be appreciably increased. Restoration of blood flow requires that the patient be seen earlier than is necessary for resection. The longest delay between onset and successful treatment among those reported was 34 hours for embolectomy and nine hours for thromboendarterectomy. The patients in our series were seen later than this as a rule and only seven of the 12 with intestinal infarc-

tion were considered in good enough condition to withstand even a brief exploratory laparotomy.

Patients with intermittent intestinal claudication or angina represent a group in which it might be possible to improve upon these results not only by relieving the functional incapacity but also by preventing future infarction. This syndrome was described by Dunphy³ in 1936. Patients typically are in the fifth or later decade of life and have other evidence of arteriosclerosis. The primary complaint is cramping abdominal pain, at first poorly localized, intermittent and induced by food, especially a heavy meal. In time, as the exercise tolerance of the intestine decreases, the pain becomes constant and is aggravated by even a light meal. It may radiate to the back and is often relieved by flexing the body or lying prone. Fear of eating and malabsorption result in large weight losses. Physical and routine x-ray examinations are usually negative or yield nonspecific findings. Among the latter we have observed, fairly consistently, calcification of the abdominal aorta, persistent collections of gas in the ileum (Figure 1) and signs of abnormal intestinal mobility including segmentation and spasm (Figure 2) and delayed ileal transit (Figure 3).

Dunphy³ reported these prodromal symptoms to have been present in seven of 12 patients dying of mesenteric vascular occlusion. It was present for six months prior to death in one of our three patients with mesenteric thrombosis. In the three patients with a primary diagnosis of intestinal angina, symptoms had been present for six to eight months. They persisted for an-



FIGURE 1

PLAIN ROENTGENOGRAM of the abdomen showing collection of gas in ileum.

other 14 months in one man before he died of intestinal infarction.

Bypass Grafting, Endarterectomy

Reports of two attempts at the surgical relief of intestinal angina have been found in the literature. In one, endarterectomy was performed successfully.¹¹ In the other a bypass graft functioned, but the patient died in a month following a series of unfortunate complications.²

Bypass grafting and endarterectomy are now well established procedures for relief of claudication in the extremities due to arteriosclerosis obliterans. The procedures are not without risk in that failure to improve circulation usually renders the limb more ischemic than it was before operation. There also is a growing reluctance in some quarters to insert grafts for claudication alone because of their relatively short functioning life. This may be due to failure of the prosthesis, progressive obliteration of the distal arterial tree or other factors.

The mortality rate of such procedures, if applied extensively to disease of the superior mesenteric artery, would undoubtedly be higher than for the extremities because of the relatively greater magnitude of the operation. Also, the consequences of failure to improve the circula-



FIGURE 2

SMALL BOWEL series 45 minutes after ingestion of barium showing an area of spasm (arrow) in the ileum.



FIGURE 3

BARIUM IN terminal ileum 6 hours after ingestion.

tion would be more serious. The three patients with intestinal angina in this series were explored only. In one no definitive therapy was considered. A bypass graft was planned in another, but the aorta was found to be too severely diseased. These patients died one and four days after surgery from coronary and inferior mesenteric artery thrombosis, respectively. Operation on the third patient was abandoned because of an adverse reaction to anesthesia and surgery. He died 14 months later with intestinal infarction.

In spite of this seemingly discouraging experience it is probable that either endarterectomy, bypass grafting or reimplantation of the superior mesenteric artery lower in the abdominal aorta could be carried out in most cases. Autopsy studies by Carucci¹ and by Derrick *et al.*² have shown that the arteriosclerotic process is invariably restricted to the proximal two cm of this artery. By limiting the length of the endarterectomy or graft necessary, this should result in a more favorable outcome than in the femoral circulation.

The only question to be answered is whether such operations, allowing for the operative failures resulting in death or requiring intestinal resection to be done, will prolong the life and improve the health of patients with intermittent intestinal claudication. More data on the natural history of patients with this syndrome as well as on the results of surgery are needed before this answer is forthcoming.

Summary

The results of treatment by intestinal resection of patients with mesenteric arterial occlusion are poor, not only in regard to survival but also in respect to morbidity among those who recover. Restoration of the occluded circulation by thromboendarterectomy, embolectomy or bypass grafting is possible and should be considered

whenever feasible. Earlier diagnosis, however, is necessary if this therapy is to be applied or even the mortality rate of resection is to be improved. This goal might be attained most easily in the case of mesenteric thrombosis by an aggressive approach to patients with the prodromal symptoms of intermittent intestinal claudication.

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Control of Surgery

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THIS IS A SUBJECT about which there has been much discussion in recent years. And many strong words have been uttered, sometimes in violent difference of opinion. It is understandable that there are some who take a very dim view of the subject and would rather not discuss it.

But let us begin at the beginning and perhaps some sort of sound philosophy will emerge. First, it is obvious that the practice of surgery is not new. It is perhaps not the oldest profession, but we do know that surgery of at least one category dates back to the skull surgeons of Pharaoh. In those days they made holes in heads to let out the evil spirits. And I am told that this art, in more elaborate form, is being practiced today. Without further argument, we can state that the crude beginnings of surgery date back to prehistoric man, and that furthermore, we have always labored under controls, some good and some bad.

A Desperate Business

In pre-anesthesia days, surgery must have been controlled, or at least inhibited, by the bloodcurdling screams of patients. It is probably true that under these conditions surgery was a desperate business. Patients were comatose, delirious, moribund or heavily drugged. And the problem of unnecessary surgery did not arise. But it was there, no doubt. Even then there must have been some unnecessary holes in heads. The question now arises, what is unnecessary surgery?

Please do not answer that question yet. If you wish to be entirely factual, we can agree that nothing is necessary except death and taxes. But

why should we be difficult when with just a little more effort we can be absolutely impossible. Let us agree that there is such a thing as unnecessary surgery. Perhaps it is an operation done by Dr. Elsewhere. Perhaps a better term would be unwarranted surgery or ill-advised surgery or just plain bad surgery.

But let us return to our theme: the first controls of surgery were pain, fear and superstition, and these were not good. Anesthesia changed the picture. In the mid part of the 19th century surgery escaped from these controls. We owe our confrères in anesthesiology a large debt of gratitude. With their help, surgeons began to acquire dignity and skill—and prosperity. But even yet, surgery was controlled or inhibited or prevented by the *surgeon's* fear of hemorrhage or infection or other disastrous complications, for which he feared criticism or condemnation.

And then came Pasteur and Lister and aseptic surgery. With modern hospital technics, surgery began to flourish. Wonderful operations were done. Surgery no longer belonged to barbers or butchers. Let me add quietly that I have heard surgeons called worse names. But the fact remains that the surgeons of the world increased in number and in prestige so that they attracted the confidence and even the admiration of the people—and became a powerful group within the medical profession.

It has been said that now surgery really got out of control. And how did this happen? The answers are not too difficult. Perhaps we should mention a few.

Unqualified men began to prowl around too freely in the abdominal viscera of patients willing to be operated upon. Too often there was the thought that the surgical fee was the chief concern of doctors involved. It was said that often the fee was "split" between the surgeon and the referring doctor in such a fashion as to offer

* Presidential Address Indiana Chapter American College of Surgeons joint meeting with Kentucky Chapter American College of Surgeons and the Kentucky Society of Anesthesiology and the Indiana Society of Anesthesiology—French Lick, Ind., June, 1960.

an inducement for the referral of patients and the perpetration of bad surgical practice. Too often these patients were women. And it should not seem strange that here began the trouble. Men have always defended women against other men whether they be surgeons or adventurers of another category! You say these accusations concerning surgery are not true? Good!

M.D. Degree Inadequate Control

But once again let us return to our theme. Surgery must have controls; and in free America, the degree "Doctor of Medicine" does not provide adequate control for surgery. There can be no argument here. When surgery is to be performed upon us or our family, we ask for qualifications and controls beyond the M.D. degree. Naturally we must insist that our patients have the same protection. Again we ask HOW?

If we depend upon the law of the land we encounter only the tangled provisions of medicolegal procedure and malpractice liability. This, believe it or not, is a control. But do we like this one? Let me give you a few examples of what may happen in this "no man's land:"

A. *The case of the "lady with the cross-eyed breasts"* appeared in the newspapers. A mammoplasty operation had been performed and had turned out badly. The unfortunate plaintiff was presented in court suitably draped for inspection by the jury. And there she sat demure and pathetic with one breast pointing upward and inward, the other one down and out.

I am not sure of the outcome of this case but let us discuss the possibilities:

1. Mammoplasty is not an illegal operation. It is usually an *elective* procedure, but when properly done, the results are good and the operation is justifiable, respectable and commendable.

2. If, however, the case in question was an operation performed by an unqualified man with an undefendable bad result, it is rightly possible that a judgment was rendered in favor of the plaintiff with an award of damages for malpractice.

B. *The case against radium for cancer of the lip* was a medicolegal situation in which a woman brought suit against a radiologist and a surgeon because radium implantation and an operation had failed to cure her husband's lip cancer.

In court it was evident that the man had not received any benefit from the treatment he had endured. In fact his condition had rapidly

"worsened" and he had died. But in this case the verdict was for the defense. The doctors involved were qualified certified men and there was no malpractice.

C. *The surgical sponge left in the abdomen* is a time-tried medicolegal problem. Our discussion of this can be very brief. It should not happen, but it does occur. It is understandable that hospitals have been given an assignment in the control of surgery. It is not the aim of this essay to enter upon a detailed recital of the devious courses the hospital control has taken, but a few brief comments are in order.

College Initiates Program

In the early days of the American College of Surgeons, beginning about 1917, the need for some standardization of hospitals in America was recognized, and the officers of the College agreed to accept the assignment with the voluntary co-operation of hospitals in the program. Time and space do not permit discussion of the valuable service rendered by the College under the provisions of this program. It became apparent, however, that the College could not and should not try to continue this responsibility indefinitely. Thus it was that the Joint Commission for the Accreditation of Hospitals was formed with voluntary participation of the American Medical Association, The American Hospital Association, The American College of Physicians and the American College of Surgeons.

The complexities of this effort are well-known, even if not always understood. Among other stringencies we now have "Hospital Audits" for appendectomy and gynecological surgery. But how about general surgery, neurosurgery, vascular surgery, plastic surgery, otolaryngologic surgery and orthopedic surgery? Are these to be audited next? We the surgeons of America must ask ourselves "Where do we go from here?"

We cannot expect the patient to assume control of surgery, even though he and she do have a part to play and should be given first consideration.

We submit that legal control is not adequate or desirable even though we have it, and had better watch it.

At the present time, hospital control is confusing us with too much regimentation in the accredited hospital, too much freedom in the unaccredited, and compromises in between.

Surgeons Must be Concerned

It is obvious that if surgery is to continue with high standards of achievement, the surgeon himself must continuously be concerned with the control of surgery. And what shall we do about this if we are to convince anyone that the best control of surgery is the surgeon, himself? Can we blindly follow Patrick Henry who said, "Give me liberty or give me death"?

We do not deny that this was a noble thought and no doubt applicable to the occasion, and not subject to argument. But is this a slogan which should dominate the thinking of a surgeon? Not really! In the life of a surgeon, liberty must be carefully defined and controlled. He must be free to be capable and courageous, but not careless or incompetent—not unconcerned, not too easily pleased with himself—certainly not unscrupulous. What then should be required of a surgeon?

In addition to normal intelligence and a medical education, he should have special training and knowledge and wisdom and integrity and a Christian appreciation of the Golden Rule.

The more we as individual surgeons adhere to these controls, the better for all concerned. I like the philosophy of the following poem:

KNOW THYSELF, CONTROL THYSELF,

GIVE THYSELF

I sought from Socrates, the Sage
Whose thoughts are lived in every age
A motto to direct my life
A hero make me in the strife
And Socrates said,

"KNOW THYSELF"

To "Know Myself" would not suffice
To make me truly good and wise
I asked Aurelius, the Great
A ruler of the Roman State.
Aurelius said,

"CONTROL THYSELF"

O Nazarene, Thou Who didst give
Thy life that other men might live
What motto wouldst Thou give to me
That I may truly follow Thee,
The Master answered,

"GIVE THYSELF"

I trust you will understand that I am not pointing a finger at anyone. No, I am talking to myself and I hope you do not mistrust the sincerity of the words.

And Socrates said, "KNOW THYSELF." How shall a surgeon know himself? He may well begin by asking himself a few questions.

Am I a pessimist? Then perhaps I should remind myself "It is better to light one candle than to curse the darkness." And when it seems that the Right has suffered defeat, the truth remains that "All great evils have within themselves the seeds of their own destruction."

Don't Be Easily Pleased

Are we optimistic? Good! But let us not be too easily pleased with ourselves. The genial optimist may be merely a happy-go-lucky fellow who does not think very straight. Thinking is the chief attribute which differentiates man from the other mammals. Hence, the term *Homo Sapiens*. Concerning this fact George Jean Nathan once commented that, even so, man's thinking is one of his most unreliable functions. There are some human beings who cannot think straight, ever. Fortunately, there are many who can and do think straight a part of the time. There are a few who think straight most of the time. No one can be expected to think straight all the time.

And Aurelius said, "CONTROL THYSELF." There are those who like to talk about natural born surgeons, but you and I know that surgeons today are mostly made, not born. A degree of natural aptitude is highly desirable. But to this should be added training and discipline and control. I submit the thought that discipline is experience which leads to self-control.

Someone has paraphrased Kipling, "If you can keep your head when all those about you are losing theirs, that is very good my son, unless it so happens that you just don't know how serious the situation is."

And if you try to tell me that control of the operating room is best maintained by an attitude of gay performance and ego-inflation for all, I am not impressed.

The Master answered, "GIVE THYSELF." The parable of the Loaves and the Fishes is especially applicable to us. The more a surgeon gives of himself, the more he is given. The time he spends rendering service, either with or without actual pay, is like bread cast upon the waters.

And now what about the surgeons pay? If he engages in private practice he must collect

fees for services rendered. But these fees need not, and must not, be exorbitant. Furthermore, I would urge the surgeon that he not be a party to unnecessary medical expense by collaborating in too many interesting but unnecessary laboratory studies and unneeded medical consultations, for which the patient, or his insurance company, must pay.

In conclusion, let us agree that all this is a large order. What then should be the qualifications of a surgeon? On one occasion, when this question was asked of my great friend Dr. Willis Gatch, he replied, "A surgeon should have

the constitution of a horse," and then he added, "It helps if he has some horse sense."

A surgeon should be a member of the order of *Homo Sapiens*, a thinking man. And now one last thought. It should be obvious that in free America no one of us acting alone can accomplish much in the way of effective control. This requires the organized effort of many men acting together. In this category, one of the most important agents in the voluntary control of surgery is and should be The American College of Surgeons. ◀

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The Ideal Physician

It is the possession of the scientific outlook that distinguishes the ideal physician from any well-veneered practitioner of the healing art. However, to study patients instead of diseases objectively requires of the observer a cultivated man capable of compassionate and perceptive responses. He must look at Nature for its own sake, as well as for the immediate value of the knowledge obtained.

Fortunately, it is the actual training in observation that matures the observer emotionally at the same time as it develops intellect in the ways discussed above. Such a "trained observer" is more impartial in his judgments and more adequate to the task in general. Whether he becomes a research worker or a practitioner, he is rewarded by the thrill of discovery—similar to that described by the surgeon John Keats "on first looking into Chapman's Homer."—Raymond L. G. Newcombe: The Value of Observation in the Training of Medical Students. *The Medical Journal of Australia*, Dec. 12, 1959.

Care of Patients Who Have Incurable Cancer

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EARLY DIAGNOSIS of incurable cancer is often hard to make. The opinion of the pathologist may be fallible. Several pathologists often give different diagnoses of the same specimen. Bloodgood said of this: "When pathologists disagree on the diagnosis of cancer the patient lives; when they agree, he dies." Furthermore, the pathologist cannot always decide whether a given growth, which is undoubtedly cancer, will establish metastases. This can be determined not by its microscopic appearance, but by its behavior.

Some few, even of the most malignant forms of cancer, such as lung cancer, spread by local extension only. I have published evidence which indicates that this is caused by a firm cohesion of their cells which keeps these out of veins and lymphatics. These tumors may exist for a long time and reach great size. I observed one of the breast which was more than 27 years old and must have weighed over three pounds. The first successful pneumonectomy for lung cancer was done by Graham in 1933 and the cancer removed must have been of this kind. The operation was done by the tourniquet method without dissection of the lung hilum. Its host is still alive.

Dormant Cancer

Closely related to non-metastasizing cancer is dormant cancer. This is cancer which survives, often for many years, in the field of operation or in a metastasis, without enlarging or giving any indication of its presence; then, suddenly, it starts an active growth. A woman consulted me

because of a tumor which had lately appeared under the scar of a nephrectomy done 33 years before for cancer of the kidney. She had had excellent health since this operation. The tumor was a cancer identical with the primary growth.

Doctor Mell B. Welborn has recently removed a nodule of adenocarcinoma from the otherwise clear site of a radical operation for breast cancer I did 24 years ago. I know of another breast cancer which lay dormant at the site of operation for 19 years, and of several others which remained so for over 10 years. Doctor Ian McDonald examined cancer-containing specimens removed from the stomachs of patients who survived operation for 10 years or longer. He found that in many of these the stomach had been cut across close to cancer; in some, right through it. Dormancy of cancer occurs frequently. Its cause is unknown. It accounts for many five-year "cures."

It may be asked: What do the foregoing facts have to do with care of the patient who has incurable cancer? They have much to do with it.

- (1) Their consideration makes you examine the meaning of "curable."
- (2) Their explanation, before operation, to an intelligent patient may give him a reasonable hope for a good result and may make him bear a bad result without being embittered at his surgeon.
- (3) They show that a patient who has incurable cancer may live with it in comfort for many years.

The late diagnosis of insurable cancer in most cases is easy to make and the limited scope of this paper makes me take it for granted. The symptoms of incurability are numerous and vary with the kind of cancer, its location and its spread; also with the patient's age, the condition of his vital organs, his social situation, and his personality. No two patients can be treated alike, but some general rules of treatment are helpful. We divide the symptoms into mental and physical and consider each separately.

Mental Symptoms

People fear cancer more than any other disease. One cause of this is the memory of the horrible mutilation and stench, which, up to recent times, attended rodent ulcer of the face, cancer of the mouth, some cancers of the breast and of other superficial parts. Disappointment of the great expectation of cure created by the propaganda for cancer control has increased this fear, and the following occurrences and others have diminished faith in accepted methods of diagnosing and treating cancer:

- (A) Deaths of Secretary Dulles and of Sen. Taft despite early diagnosis and presumably the best possible treatment.
- (B) Deaths from lung cancer of Dr. Graham, who did the first successful pneumonectomy for lung cancer, and of Dr. Horax of the Lahey Clinic both only a short time after they discovered that they had it.
- (C) Demonstration by numerous workers of cancer cells in venous blood.
- (D) Failure of early and radical operation to lower the death rate of cancer.

Mental suffering of the patient with incurable cancer is frequently greater than his physical suffering and always aggravates this. It often is the only suffering he has. It can sometimes be allayed by explaining to him that cancer is often dormant. Never take all hope away. The most valuable treatment is constant and intelligent companionship along with conversation which diverts the patient's mind from his affliction. This should be judiciously supplemented with tranquilizing and hypnotic drugs.

Here comes the question of whether to tell the patient he has cancer. No fixed rule can be

set for this. It is wise, I think, not to tell him unless he forces you to do so, and often he does not. His mind may ignore the certainty of his impending death. Should demands of religion or of property disposal require that he be told of his fate, he should be told before his mind is impaired. You must never fail to tell the most reliable member of his family.

Physical Suffering

Physical suffering comprises pain and interference with body function, and is usually associated with mental suffering. This discussion is on palliative treatments only. These are numerous: Radiation operations on the nervous system to stop pain, the administration of appropriate hormones (as stilbestrol for cancer of the prostate) for hormone-associated cancers, removal of glands of internal secretion (pituitary, adrenals, testicles, ovaries), perfusion of cancer-containing tissue with solutions of nitrogen mustard or of other drugs and operations to prevent or remove conditions, as bowel obstruction, which immediately threaten life. The benefits claimed for some of these demand scrutiny, for they are potent psychotherapeutic treatments and the patients who receive them will trust any cure. We should be certain that any treatment we give will not increase or prolong the suffering of a patient who is about to die.

Sedative drugs, after all, remain indispensable to the treatment of these patients. There should be no fear of making addicts of them. An addiction which can make them happy till they die is a blessing.

A final question. How long should you try by every possible means, to keep the patient who has incurable cancer alive? The answer is, till no useful purpose to him or to others can be served by prolonging his life. You must do nothing to end it, but under the assumed circumstances you need not take extraordinary means to prolong it, e.g. to keep alive a patient in coma caused by a brain metastasis.

To those of you who practice in Catholic hospitals it is of interest to know that this is the doctrine of the Catholic Church. Father Thomas Finneran of Indianapolis informs me that this rule was stated by Pope Pius XII in an address to anesthetists in 1957. It wisely leaves what is to be done in each case to the judgment of the surgeon. ◀

Management of Rectum and Rectosigmoid Cancer In Elderly Patients

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THIS STUDY deals with patients having malignant diseases of the anus, rectum and rectosigmoid, treated by surgeons of the Welborn Clinic from Jan. 1, 1947, through Dec. 31, 1959, with particular emphasis on management of the elderly patient. During this period we observed a total of 178 patients with malignancies in this area. Of this total, 95 were 65 years of age or older. Table I records the type of treatment carried out in this older age group.

Combined abdominoperineal resection is a major surgical procedure associated with considerable trauma. One wonders whether or not elderly patients can survive this procedure with relatively low morbidity. In order to attempt an answer to this question our experience was studied and will be compared with that of others. The total number of patients in the older age group having combined abdominoperineal resection was 36, and in the group under age 65 the number was 43, for a total of 79. There were seven deaths in the entire series of combined abdominoperineal resections. In the age group 65 and over there were three deaths. These will be commented up briefly.

Deaths in Over-65 Group

The first was in an 83-year-old white male doing quite well, only to die abruptly on the fourth postoperative day from what was thought

to be a massive pulmonary embolism. The second death was in a 65-year-old white male, the cause of death being somewhat obscure, in spite of the fact that he came to autopsy. In retrospect, one wonders whether or not it was not due to electrolyte imbalance. The third elderly patient to die was a white man age 82, with known adenocarcinoma of the rectum for at least one and one-half years; surgery at first was not advised due to severe cardiovascular disease with heart failure. However, after being managed by conservative measures for nine months, severe bleeding and tenesmus caused surgery to be carried out for a large, bulky, ulcerated rectal lesion accessible to digital rectal examination. He did well until the fourth postoperative day, at which time a painful posterior pack was removed, and from then on he deteriorated rapidly and died in congestive heart failure.

Younger Group

In the group under age 65, the first death was that of a former wrestler who was very strong and heavy, weighing 240 lbs. The operative procedure was technically difficult but he was doing well until the fifth day, at which time he became somewhat confused, even though he was ambulatory.

He developed an icteric tinge to the sclera and presented symptoms somewhat similar to those noted in delirium tremens, although he was not an alcoholic. The autopsy here did not clearly

* From the Surgical Service of the Welborn Clinic and the Welborn Memorial Baptist Hospital.

delineate the cause of death, but speculation since has been that perhaps he may have died from multiple small fat emboli to the brain.

The second death was a 58-year-old white female with extensive fixation of a very large neoplasm, necessitating removal of a part of the left ramus of the pubis, who died from peritonitis on the eighth postoperative day.

The third death was that in a 54-year-old white male admitted with acute colonic obstruction and marked emaciation. A two-stage type of procedure was elected, the patient succumbing following the second stage from hemolytic staphylococcal aureus wound infection.

The fourth and last death in the younger age group was that of a 54-year-old white male, who died abruptly on the ninth postoperative day, the autopsy revealing coronary occlusion.

Overall Mortality is 8.8%

Thus, it is seen that in the 36 patients of 65 years of age or older, undergoing combined abdominoperineal resection, either in one or two stages, there were three deaths, and in the 43 patients under 65 having similar procedures, there were four deaths for a total of seven among 79 patients for an overall hospital mortality rate of 8.8%.

Table II records the mortality rates from a few authors carrying out procedures in patients from 65 to 70 years of age or older. Mortality statistics relating to elderly patients having radical surgery for cancer of the rectum were meager.

Table II illustrates that major surgery in elderly patients is associated with a high overall hospital mortality, but that apparently radical combined abdominoperineal resection for cancer of the rectum can be carried out with a mortality that compares favorably with other major procedures in this age group. Our experience with 79 patients having the radical combined abdominoperineal resection for cancer of the rectum is that the mortality in the older and younger age groups is approximately the same, being about eight to nine percent.

One should not interpret these statistics as advocating that radical surgery is indicated in all elderly patients with cancer in this area, but rather that in that group requiring such procedures—and reference is made primarily to those patients with obstruction, hemorrhage and tenesmus—that with care radical surgery can be ac-

Treatment carried out in patients 65 yrs. of age or older

Treatment	No. Patients
Single stage combined abdomino-perineal resection	34
Two-stage combined abdominoperineal resection	2
Three-stage exteriorization procedure	1
Anterior resection	12
Radical local excision with inversion of the distal rectal segment	8
Transcolonic excision of a malignant polyp	2
Palliative colostomy	3
Laparotomy with biopsy	9
Posterior excision with colostomy	1
Radical local excision by transrectal approach	7
Proctoscopy with biopsy only	6
External irradiation only	2
Medical treatment	7
No treatment; died soon after admission	1
Total	95

TABLE I

complished with a hospital mortality rate that compares favorably with other major procedures. It must be emphasized that each rectal malignancy will have its own biologic character, but that in general they tend to be rather indolent, slowly growing tumors whose invasive potential and tendency to spread to the regional lymph nodes is comparatively low.

Conservative Approach

Viewed in this light an elderly patient with a short life expectancy might better be managed by no treatment at all, or perhaps by a conservative method. Brindley,⁴ apparently thinking along similar lines, managed 20 patients who either because of advanced age, serious systemic disease or refusal to permit more radical surgery, had local excision of what he termed early small malignant lesions of the rectum. There was no surgical mortality and only one recurrence in a period of five years. Wittoesch and Jackman³ presented a similar series of 128 patients treated by fulguration, excision, irradiation or a combination of these methods. They were surprised to find that 54 of the 116 patients were living more than five years after initial so-called con-

Mortality rates reported by various authors in elderly patients

Author	No. Patients	Type Operation	Overall Mortality
Oberhelman ⁵ (1954. 70 yrs. or older)	139	Major abdominal surgery	8.6%
Welch* (1948. 70 yrs. or older)	140	Major abdominal surgery	20%
Childs & Mason* (1949. 70 yrs. or older)	99	Major abdominal surgery	14%
Parsons ² (1956. 70 yrs. or older)	135	All types gen. surgery	8%
Dvoskin ⁶ (1958. 65 yrs. or older)	134	All types cancer surgery	10%
Gregg ¹ (1959. 70 yrs. or older)	?	Radical comb. abdominal perineal resection	18%
Welborn (1947-1959. 65 yrs. or older)	36	Radical comb. abdominal perineal resection	8.3%

* Cited by Oberhelman.

TABLE II

servative treatment. Six were living more than 10 years later and 24 of the 75 deaths were unrelated to rectal carcinoma.

It will be noted that in our series of elderly patients seven were managed by radical local excision by way of a transrectal approach. This method is only suitable for relatively low lying, anatomically small, superficial lesions, ideally located on the posterior rectal wall. With the patient lying on his face, the anal sphincter divulsed or divided, one can reach surprisingly high along the rectal tube, carrying out a rather wide radical cold knife excision, without undue technical difficulties. The morbidity following all types of surgery for neoplastic lesions in this area is somewhat high, but as is to be expected, it is lower when the more conservative procedures are executed.

This is illustrated by an obese 76-year-old white female with a small posterior, 8 cm level rectal lesion managed by combined abdominoperineal resection. The pathologist reported adenocarcinoma without invasion of the muscular wall and with negative nodes. She is living and free of recurrent disease eight years later, but in the interim has required three revisions of the end sigmoid colostomy. Could this patient have been better managed by radical local excision?

A second patient, a white male in his early 50's with a polypoid lesion inside the anal verge, was told by one surgeon that he had cancer and by another that it was a hyperplastic polyp. The lesion was treated by fulguration and local ex-

cision. From time to time small recurrences were treated in like manner. In January, 1956, frank invasive adenocarcinoma was demonstrated and there were firm lymph nodes in each groin. At the time of radical combined abdominoperineal resection in 1956 lymph nodes from the groin revealed metastatic disease. He remains well now, some four years later, free of clinical evidence of recurrence of the new growth.

Summary

We have reported on 178 patients with cancer of the rectum and rectosigmoid; 95 over age 65 are studied in some detail, particularly in regard to radical combined abdominoperineal resection. This operation was done in 79 patients, 36 of whom were 65 years of age or older, and three of whom were hospital deaths for an operative mortality of 8.3%.

This mortality compares favorably with less major procedures carried out in patients in this age group. It is emphasized that cancer in this area frequently is biologically rather indolent, progressing rather slowly. However, due to its large size, to obstruction, to hemorrhage or to tenesmus, radical surgery may be indicated and still represents the best method of treatment for this disease.

On the other hand, there is a small group of patients who for one or a combination of more than one reasons, may have to be managed by a more conservative approach. Radical local excision for anatomically small, superficial lesions

has been found satisfactory for this group. This can be combined with other methods, such as fulguration or irradiation.

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Accidents Claim Lives of Many Women

Last year about 11,000 American women at ages 15 to 64 years were killed in accidents, it is reported by statisticians of the Metropolitan Life Insurance Company.

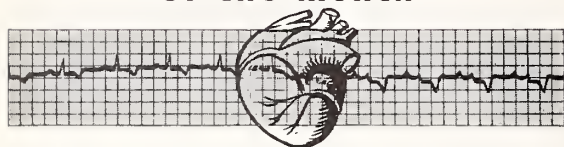
Among women at these ages, accidents take twice as many lives as pneumonia and nearly five times as many as tuberculosis. During adolescence and early adult life, accidents outrank every other cause of death among women.

Motor vehicle accident fatalities far outnumber those sustained in any other type of mishap, and account for three-fifths of all fatal injuries among white women at ages 15 to 64 and nearly half the total among colored women. Most of these women were occupants of automobiles—either as passengers or as drivers—when fatally injured.

Falls rank second, and fires and explosions third as causes of accidental death. Other types of accidents adding to the death toll are poisoning by solids and liquids (mainly the ingestion of barbiturates and other drugs), drowning, poisoning by gas and wounding by firearms.

Only one-fifth of all fatal injuries among women at ages 15 to 64 occur in and about the home. Even more surprising, fewer than 50 accidental deaths a year occur among women in industrial places, despite the millions of women gainfully employed in the United States.—*N. Y. State Journal of Medicine*, Oct. 1, 1960.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, *Electrocardiogram of the Month* is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Master Two-Step Exercise

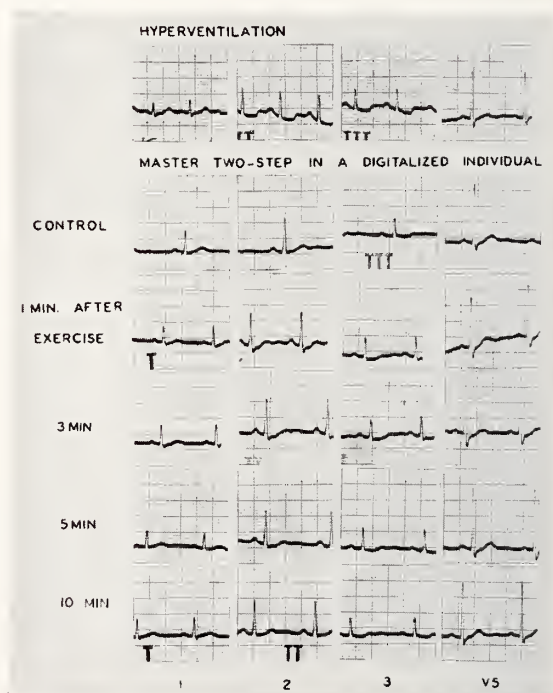
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TESTS DESIGNED to induce myocardial ischemia in patients with suspected coronary disease but with equivocal history and physical findings are extremely useful at times. With proper safeguards and, what is more important, with careful and accurate interpretation of the electrocardiographic changes, the Master two-step is the most practical. With increasing experience gained from the wide application of this procedure certain situations which could produce a false positive test are now recognized.

Hyperventilation and digitalis will occasionally product a ST-T segment shift in the absence of coronary disease, even when the resting tracing shows no evidence of digitalis effect. It is important therefore, that digitalis be discontinued for about two weeks prior to performing the test and a record after 30-45 seconds of hyperventilation be obtained first. The differential diagnosis between a positive Master two-step due to coronary disease and one due to digitalis may be extremely difficult. An useful criterion which helps to separate the two is the duration of the

* Supported by the Herman C. Krannert Fund of the Indiana Heart Association, Indiana State Board of Health and The National Heart Institute (H.T.S. 5363).



This figure shows the control tracing (row 2) and the effect of hyperventilation (row 1) with a definite change in the ST-T segment in leads II and III and some diminution in height of T wave in V5. In rows 3-6 are shown the changes resulting from exercise with depression of S-T segments in leads II, III in strips recorded, 1, 3 and 5 minutes after exercise.

Q-T interval. In nearly all cases of positive two-step due to myocardial ischemia the Q-T interval is prolonged while in changes due to digitalis the Q-T is shortened.

Case Report

The patient was a 39-year-old male who was evaluated carefully on two separate occasions and was followed closely because of two episodes of atrial fibrillation which subsided spontaneously.

As a part of the study a Master two-step was performed which was normal. Following this the patient was given quinidine and digitalis. In the course of re-evaluation the two-step test was repeated at a time when the patient was receiving digitalis. (See Figure 1.)

The upper row shows a response to simple hyperventilation. When compared with the control tracing (row 2) one sees a depression of ST and T wave in lead II and III. This is a rather striking change and could lead to an erroneous diagnosis of coronary disease. Rows 3, 4, 5, and 6 present the changes occurring with exercise. Unquestionable depression of ST segment is evident in lead II and III, one minute, three and five minutes after exercise. Ten minutes after exercise the changes revert to normal. These changes could be interpreted as suggestive of a positive Master two-step were it not for the fact that the patient was receiving digitalis. There is no prolongation, if anything, the Q-T interval is shortened in course of exercise. ◀

Physician as Listener

The therapist should be a good listener. Even more important, he should have some knowledge of semantics and should reveal to the patient that he is interested in what the patient is saying. He should betray it in his manner and his personal expression as well as in what he says after the patient has expressed his opinion. Remember that a receptive ear receives the richest harvest. As a listener, the physician increases his knowledge of human nature, and he adds to his own store of cultural refinements. He will find that in enabling his patient to talk of interests other than personal aches and worries, he has effected the best therapy possible.—Martin, A. R.: *Recreational Measures and Their Value to Older People*, *J. Am. Geriatrics Soc.* 7:536 (July) 1959.

LABORATORY MEDICINE

Published periodically as a review of clinical laboratory procedure suitable for laboratories with minimal equipment.

Urinary Protein

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KIDNEY FUNCTION TESTS are important in the diagnosis and care of patients with kidney diseases as well as extrarenal conditions which affect the kidneys. Most kidney function tests of the complexity of the urea clearance, phenolsulfonphthalein test and other clearance tests do not lend themselves well to the small laboratory. Some of the older time-honored laboratory procedures which roughly quantitate the urinary protein are of great use as a screening procedure until more specialized help and equipment can be obtained.

Normally urine contains a small amount of albumin which can not usually be detected by our routine methods. Globulin is also sometimes found, and these two collectively are called albumin, thus the inclusive term albuminuria. Not all albuminuria is renal or true albuminuria incident to disease; some is false or accidental albuminuria due to blood, pus, and the like. Such entities as physiologic and orthostatic albuminuria should be considered; however, if albuminuria is present, further investigation of the patient is necessary. Albuminuria associated with granular casts is definitely an important finding, usually a sign of serious kidney damage. Bence-Jones protein will not be discussed at this time.

A modification of the Exton's Qualitative test for urinary protein and Tsuchiya's modification of Esbach's quantitative method will be dis-

cussed. Although the "stick" tests are in vogue, there is still a need for a chemical test.

METHOD: Qualitative (Exton)

Place approximately one ml of the supernatant portion of centrifuged urine in a test tube. Add three drops of 20% sulphosalicylic acid. Compare with centrifuged specimen without added sulphosalicylic acid and note the amount of albumin present by the density of the cloud. These should be reported as follows: very faint trace, faint trace, trace, and heavy trace. All urines that read above a heavy trace should be run quantitatively by the Tsuchiya's method. The dye used in intravenous pyelograms will cause a false positive reaction with the qualitative test. After standing a few minutes, the urine will clear and appear crystalline. Intravenous pyelogram dyes will not react with Tsuchiya's reagent. Massive doses of penicillin and plasma expanders will also give false positive results using sulphosalicylic acid as an indicator for protein.

METHOD: Quantitative (Tsuchiya)

Place any amount of centrifuged urine not exceeding eight ml in a graduated conical centrifuge tube. The amount depends upon the amount of albumin judged to be present when the qualitative test was done. Two to four ml is usually sufficient. If less than eight ml of urine is used, dilute to eight ml with distilled water and multiply the results by the appropriate factor. Add

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five ml of Tsuchiya's reagent. Invert the tube three times and allow the tube to stand one minute. Centrifuge at full speed for 15 minutes. Read the volume of packed precipitate. If the volume of precipitate is over one ml, repeat, diluting the urine further.

CALCULATION

With undiluted urine, each 0.1 ml of precipitated protein is equivalent to 0.036 gms of protein per 100 ml of urine:

ml. ppt.	Gm% protein
0.1-----	0.036
0.2-----	0.072
0.3-----	0.108
0.4-----	0.144
0.5-----	0.180
0.6-----	0.216
0.7-----	0.252
0.8-----	0.288
0.9-----	0.324
1.0-----	0.360

For every 0.35 grams of total protein per 100 ml subtract 0.001 from the specific gravity reading.

Tsuchiya's reagent may be prepared by diluting 15 gms of phosphotungstic acid and 50 ml of concentrated hydrochloric acid to 1000 ml with 95% ethyl alcohol.

Urine that is grossly bloody will give a high erroneous albumin reading. This specimen is unsatisfactory for albumin determination.

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Jobs Unhazardous

Occupational hazards will no longer be a consideration in determining acceptance of life insurance applicants by 1965, predicts the Institute of Life Insurance, New York. "The great improvement in industrial safety and preventive medicine have at this point almost removed occupations as the major factor in determining insurability."

Today, for example, only experimental jet pilots remain totally uninsurable as a group. Taken off the uninsurable list in recent years were steeple jacks, deep sea divers, airline pilots and radium dial painters. Other occupations, formerly uninsurable, are now insurable but must pay higher than average premiums. These groups include: Drivers trucking nitroglycerine, chemical workers handling explosives, caisson workers, building wreckers and military pilots.—*Industrial Relations News*, Sept. 10, 1960.



*attains
sustains
retains*

*extra
antibiotic
activity*

DECL

attains activity levels promptly

DECLOMYCIN Demethylchlortetracycline attains — usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustains through the entire therapeutic course, the high activity levels needed to control the primary infection—to check secondary infection at the original—and another—site. This combined action is usually maintained without the pronounced hour-to-hour, dose, peak-and-valley fluctuations which characterize other tetracyclines.

TETRACYCLINE
ACTIVITY
WITH
DECLOMYCIN
THERAPY

DOSAGE
150 mg. q.i.d.

TETRACYCLINE
ACTIVITY
WITH OTHER
TETRACYCLINE
THERAPY

DOSAGE
250 mg. q.i.d.

DECLOMYCIN—SUSTAINED ACTIVITY LEVELS

OTHER TETRACYCLINES—PEAKS AND VALLEYS

POSITIVE ANTIBACTERIAL ACTION

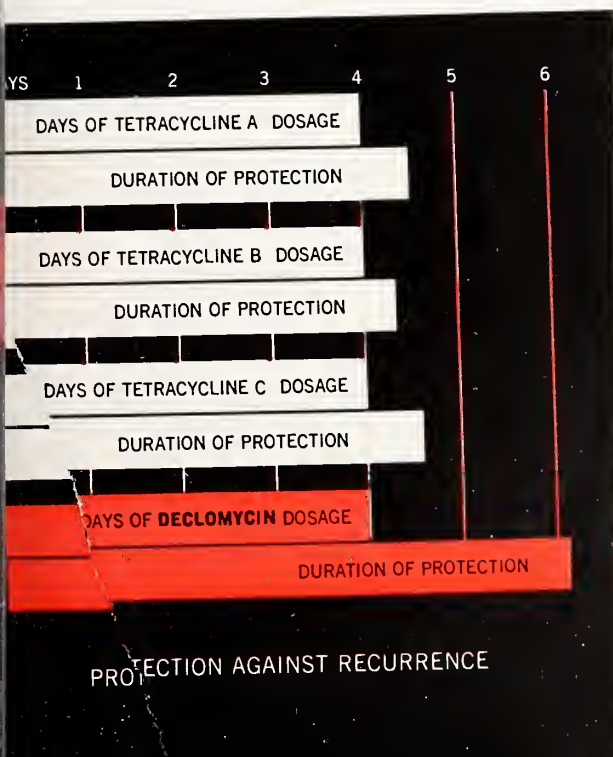
PROTECTION AGAINST PROBLEM PATHOGENS

DECLOMYCIN[®]

DEMETHYLCHLORTETRACYCLINE LEDERLE

retains activity
levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines...but **total** dosage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.



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Better Passenger Packing

*A*UTOMOBILE SAFETY was the big topic recently at a meeting of the American Association for Automotive Medicine. Doctors from all over the United States, interested in auto racing and particularly in safe auto racing, held a safety seminar at Dearborn, Mich. A poll conducted by the *AMA News* produced some good advice from the experts.

Better packaging for the passenger was the theme. A valuable article packaged for transportation must be provided first of all with a package which will not crush in on the contents, burst open or spill out the contents. In addition the contents must be fastened within the package to prevent violent dislocations and breakage.

The doctors overwhelmingly "rated seat belts as the most important single, economically feasible device now available to protect passengers." A well-belted passenger is analogous to a teacup in a barrel of excelsior; a passenger without a belt is in as much danger as a teacup being transported loose within the barrel.

Measures to improve the safety of the interior of the package were discussed. One of the most important of these is elimination of all projections in the inside of the car and the padding of

all projections which cannot be eliminated.

Other improvements mentioned included safety door locks to prevent ejection of passengers with a doubling of the injury rate; high seat backs to prevent "head snapping;" deep-dish steering wheels to prevent chest injuries; and the elimination of the ledge behind the back seat. Eliminating the back seat ledge is important since it is the catchall which contains loose and useless articles destined to become missiles in time of an accident.

A suggestion was made to have seat belts built in at the factory, although the big problem is to convince drivers and passengers to use them. Usually anyone convinced of the wisdom of seat belts will have them installed as an extra. Having them in the car, but not used, affords no protection at all.

The AMA, National Safety Council and the U. S. Public Health Service is now conducting a year-long study in Fort Wayne, Indiana, to educate the public on the advantages of seat belts. Seat belt sales are away up in Fort Wayne and lots of people are interested. The study is being continued to determine techniques a community can use to encourage the use of belts.

Good Servant—Terrible Master

FIRE IN THE UNITED STATES set a new record in 1959 for lives lost and value of property destroyed—2,115,000 fires were reported, a figure which has been exceeded only once by 2,400,000 fires in 1950.

What made the 1959 experience the worst on record was the 11,300 lives lost and the \$1.4 billion of property value destroyed.

Almost half of the fire fatalities occurred in homes in which 27 dwelling fires accounted for 195 of the deaths. Inadequate escape facilities and failure to plan for fire emergencies in the home were the major factors in 188 of these 195 deaths.

It is apparent from the annual report of the National Fire Protection Association that most if not all fires are preventable. Building fires are due chiefly to defective or overheated cooking and heating equipment, careless smoking and defective electrical wiring. In addition, rubbish started and fueled 57,000 fires at a cost of \$21 million.

Hospital fires are grouped with those of other custodial institutions. This classification set a doleful five-year record in 1959 with an estimated 2300 fires as against an average of a few over 1600 over the previous four-year period. Dollar losses in 1959 were \$3,390,000.

Almost 100 children die in fires each month as a result of being left unattended or with sitters incompetent to cope with an emergency. The National Association advocates the best of protection for children, as well as regular fire inspections, fire rules and fire drills for the home. Previously planned and practiced double escape routes from every room in the house are recommended for children and adults as well.

Many people lose their lives by re-entering a burning building after they have successfully escaped. The rule here is "Once Out—Stay Out."

Almost all fires are the result of carelessness. All deaths are the result of failure in disaster planning.

Changing Face of Blindness

PROGRESS in medicine and surgery has not been made without some high price tags. The prolongation of life reflects the problem of increased blindness in the aged. This poses a serious socio-economic problem. With an estimated blind population of 350,000 in the U.S.A., over half of these are in the older age group.

Legal blindness is defined as the reduction in vision to 20/200 or less in the better eye. A few decades ago infectious diseases and injuries accounted for most blindness. Today, general disease such as hypertension, arterio-sclerosis and diabetes, along with specific diseases such as glaucoma and cataracts, account for 50% of blindness. These diseases usually affect the older age group. The incidence of blindness rises sharply from 35 per 100,000 in persons under 21 years of age to 1,200 per 100,000 in persons 65 and over. The same medical advances that have served to reduce blindness in the young have also served to prolong life with the sharp increase in blindness in later years.

The role of high oxygen administration in the newborn has been shown to be the cause of retrolental fibroplasia in which fibrous tissues form behind the lens. Prevention is the keynote of treatment, as there is no effective cure. This condition is rare since the etiology has been established and the cautious use of oxygen employed.

About 50% of the blindness in older folks is preventable or remediable. Early recognition and treatment of glaucoma will prevent approximately 14% of the blindness in our old. A screening tonometric examination is the simple office procedure and this service should be available to all patients. Prompt diagnosis and treatment is a strong prophylactic measure.

Cataracts are the most important cause of visual loss in the aged, accounting for 16% of blindness. There are no preventive measures, but the surgical prognosis is good in most cases.

General diseases are responsible for eight percent of blindness. There is no effective preven-

tion or treatment for degenerative retinal lesions but there is some evidence that diabetic control will minimize the retinal lesions over a period of years.

There is no easy answer to the problem of blindness in the aged. Screening technics will

become more widespread; public education will be pursued; and research will eventually solve some of these problems. However, the socio-economic problems of the blind will ever be with us.—
Carl B. Harris, M.D., Indianapolis

Editorial Notes

Eli Lilly researchers have found that the sensitivity of bacteria to some antibiotics is altered if the reaction is tested in blood serum rather than standard media. A strain of staphylococcus aureus was found to be considerably more sensitive to streptomycin when tested in human serum. Some antibiotics were less active in serum than in broth. The new method of sensitivity testing may prove to be of great assistance in combatting resistant strains.

Clinical observations at the Central State Hospital in Indianapolis show that combined therapy of malaria and penicillin is more effective in general paresis in reversing the Wasserman reaction than is treatment with malaria or penicillin alone. Dr. Herbert Fleischl, in the November issue of *Journal of the American Geriatrics Society*, reports results in 35 patients with paresis; 29 of the 35 received malaria treatment and later some of these also received massive doses of penicillin. Six patients received penicillin only. In all those who received penicillin exclusively the Wasserman reaction remained positive. In seven of the patients treated with malaria, and in 11 of those treated with both malaria and penicillin, the Wasserman became negative.

Indiana Blue Shield passed a large milestone recently when the total of its payments to members exceeded the \$100 million mark. Blue Shield was organized 14 years ago and since then has paid out on behalf of its members \$100,859,183.28 covering some 2,670,759 claims; 91 cents of each dollar received from members is now being returned in benefits. At the end of its first year membership was 121,417. Today membership is 1,377,308.

Medical schools of the United States conferred the M. D. degree on the largest class ever in 1960: 7081 doctors graduated this year as compared with 6860 in 1959. The previous record was 6977 in 1955. Six schools reported increases of over 15%. Present maximum enrollment is 8188. This could be increased to 9894 first-year students if all schools were able to expand to maximum enrollment without overload.

The Surgeon's General Consultant Group on Medical Education has estimated that facilities to handle 12,000 first-year enrollees should be provided by 1971 in order to maintain the present ratio of physicians to population. This will obviously require more medical schools.

Recent additions are the University of Florida College of Medicine which graduated its first class in 1960; the West Virginia University School of Medicine which is expanding from a two-year course to full four year and the University of Kentucky College of Medicine which enrolled its first class this fall. The AMA Council on Medical Education and Hospitals, which furnishes the above figures, also reports a sharp increase in planned expenditures for medical school construction expansion—about 126 million dollars—up 140% over last year.

Major Medical Expense Insurance is being acquired by millions of people every year. In five and one-half years since 1955 the number of persons covered has risen from 5.2 million to 24 million. One out of eight persons in the U. S. now enjoys this protection against catastrophic illness.

A typical Major Medical policy, according to the Health Insurance Institute, has two identifying features—the deductible and co-insurance. These are the features which make it possible to

pay out huge benefits and still keep the premiums at a reasonable level.

The deductible feature is similar to the same thing in auto insurance—an amount ranging from \$25 to \$500, depending on the policy, is specified as the portion the insured pays before the policy benefits begin.

The higher the deductible, the lower the premium. Coinsurance specifies the proportion of the entire bill which the insured shares with the company. Usually the company pays from 75% to 80% of the entire bill, after the deductible has been subtracted. Both these features make the insured a partner in the transaction. Deductible clauses eliminate small claims, and co-insurance clauses tend to eliminate unnecessary expenses.

A U. S. Chamber of Commerce study of the payrolls of 108 companies shows that fringe benefits have been steadily increasing since 1947. Fringe benefits now amount to almost one-quarter of the total pay, in fact \$22.80 out of every \$100. This adds up, for the companies surveyed, to a cost of 60.7 cents per payroll hour. On the average the employees of 1064 U. S. firms receive \$1,132 annually from the fringe.

It has been customary to attribute lengthening of the life span in the United States to reductions in mortality of children and young adults. A large part of the increase has been for this reason, but the decrease in mortality for people above 60 years of age has been substantial. Between 1929-31 and 1958 white males achieved an average decrease of mortality

amounting to 13% for all age brackets between 60 and 80. Women made greater improvements with reductions in mortality amounting to 47% at age 60, 40% at age 65 and to more than 30% up through age 80. (Statistical Bulletin, Metropolitan Life Insurance Company)

Although used in a far from optimal fashion due to public apathy Salk vaccine has achieved a remarkable record. The Statistical Bulletin of Metropolitan Life states that "the incidence of poliomyelitis in the United States for the full year 1960 will be appreciably below that for any year since the introduction of the Salk vaccine in 1955, and far below the annual number of cases in the pre-Salk period." The estimate for 1960 is 3,000 cases. There were 8425 cases reported in 1959, 5485 for 1957. In 1955 there were about 29,000 cases and the annual average from 1950 to 1954 was 39,000.

The Arthritis and Rheumatism Foundation, through its president Floyd B. Odum, announces a national conference to discuss the health menace posed by quackery in arthritis "remedies." The meeting will be held in Washington, D. C. early in March, 1961. It will consider the problem from multiple viewpoints—medical, legal, promotional, manufacturing and consumer. It is estimated that arthritis sufferers are spending more than \$250 million each year on deceitfully advertised products. Mr. Odum said that the purpose of the conference will be to consider ways of protecting some 11 million victims from exploitation and quackery.

Overspecialization

Despite the obvious need for a greater supply of family physicians, and despite the just as obviously expressed desire of the American people for an increase in the supply of family physicians who will assume this total continuing responsibility for the health of the individual and his family, there is incontrovertible evidence to prove that our present system of medical education and our present system of hospital organization are contributing to the demise of the general practice rather than to its survival.—W. B. Hildebrand and John S. De Tar: *The Relationship Between the General Practitioner and the Specialist. Minnesota Medicine*, Nov. 1959. Reprinted in the *U. S. Armed Forces Medical Journal*, Vol. 11, No. 11.

President's Page

An Open Letter to Our Next (?) President

Honorable John F. Kennedy,
President-Elect of the United States,
The White House,
Washington 25, D.C.

My dear Mr. Next (?) President:

One of the requirements of the President of our Association is that he write a page for our *Journal* each month. Likewise, he is admonished that the material for his page must be in the hands of the printer prior to the fifth day of the month preceding its publication. This piece, therefore, is written the latter part of November, at a time when there is still some doubt that the election has been decided and faint hope exists that good old Mississippi may give the decision to the House of Representatives for a final go-around. Faced with the remoteness of this possibility the advice herein contained will reach you about a week before your Inaugural.

Indiana, Mr. President, is one of the proud states which furnished a haven for one of our great Presidents, Mr. Abraham Lincoln. We in Indiana are imbued with the traditions left to us by the "Great Emancipator." During the last campaign it was refreshing that you too, recognized the God-given qualities of this man, so it is indeed appropriate that we furnish you with his ten commandments of human behavior. They follow:

You cannot bring about prosperity by discouraging thrift.

You cannot strengthen the weak by weakening the strong.

You cannot help small men by tearing down big men.

You cannot help the poor by destroying the rich.

You cannot lift the wage-earner by pulling down the wage payer.

You cannot keep out of trouble by spending more than your income.

You cannot further the brotherhood of man by inciting class hatred.

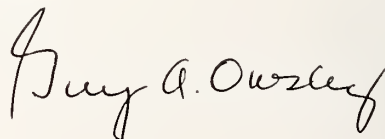
You cannot establish sound security on borrowed money.

You cannot build character and courage by taking away a man's initiative and independence.

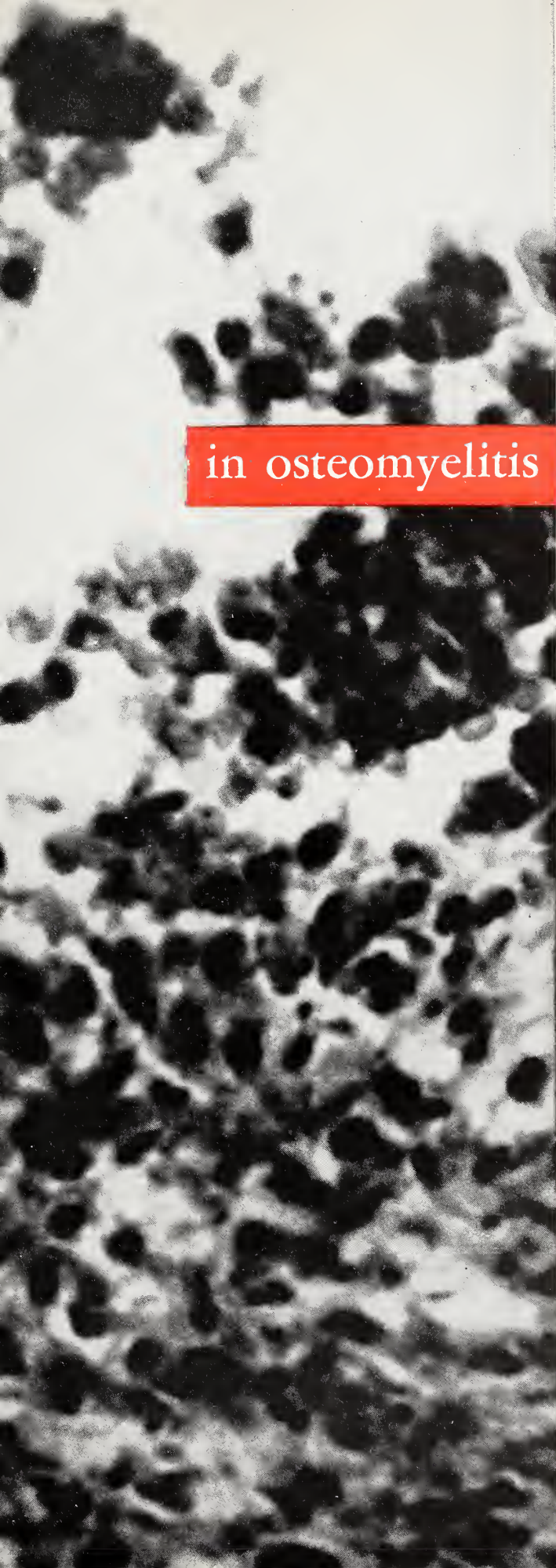
YOU CANNOT HELP MEN PERMANENTLY BY DOING FOR THEM
WHAT THEY COULD AND SHOULD DO FOR THEMSELVES.

Think it over Mr. President—and O yes—be sure and show it to your architect,
Chester Bowles.

Sincerely,



P.S. The same to you Mr. Nixon -----just in case.



in osteomyelitis

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Most Social Security monies are used to pay government bills; yet the program is ever closer to cradle-to-grave coverage.

Socialism—more specifically, Social Security

B. D. WAGONER, M.D.

Union City

WOULD YOU LIKE to have your federal income taxes lowered? It can be done and you can do something to bring it about.

I would guess that the majority of people are under the impression that most of big government expenditures are due to what has been termed *defense spending*. The fact of the matter is that the road to inflation is almost totally unrelated to spending for national defense. Mr. Paul Morrison of Northwestern University points out that rising government costs are due to two factors—the steady growing demands of the public for more services from Washington and the bowing to these demands by politicians in their eager quests for votes.

I would like to focus on one particular phase of government spending with which we are all directly concerned. I suppose you are wondering to what I am referring. I am referring to socialism—to be more specific, social security.

There are certain facts that I would like to present to you concerning social security, which has been a part of the American way of life since 1935. It is big business and an ever-increasing compulsory taxation. The taxes which are paid into the social security fund and are not needed for current withdrawals are spent by the government for its general needs, and the government in turn gives the fund its I.O.U. in the form of government bonds, the interest on which must be met by increased taxation.

Why do we have it?

Why do we have social security in the first place? Why should we provide for the segment of the population that would not or could not save for retirement? The answer is that of this segment, a certain percentage has never been

fortunate enough to have gainful occupation in order to save for retirement. Many workers were retired, due to age, when they were quite capable, mentally and physically, to continue work, but had no funds to support themselves. The main purpose of the fund then was to protect any person who came to the end of his working days and had no savings or funds . . . What does this mean to you??

Is this something our government should take care of for us or is it up to us as individuals to do something about it? I do not think the government owes anyone a living. Thrift, security and saving must continue to be praised in our country. I agree that the federal handout system is needed in many cases and that is why we have it, but why not keep payments at a minimum? Why should the industrious hardworkers who might accumulate something in life be forced to pay an exorbitant bill for the bums, the lazy shiftless people who will always put pressure on politicians for bigger and bigger handouts? Proponents for social security not only want the monthly payments increased, they also want medical, dental, ocular and hospital bills paid by the government.

From a philosophical viewpoint there is no such thing as being a little bit pregnant or a little bit dead. The same is true of socialism. Either you are for it or against it. The social security program, since it was first enacted in 1935, has moved farther and farther away from the original concept of providing a floor for financial protection for old age. It is moving closer and faster toward cradle to grave coverage. These lawmakers are not dismayed by the deficit now existing in social security funds. They favor increasing the base which is taxed.

What is the condition of the social security trust fund? The liabilities for current and future benefits are now estimated at over 361 billion dollars. Less than seven percent of this liability is backed by reserve funds. The fund contains approximately 21 billion dollars worth of government I.O.U.'s. Most of the social security tax monies have been used to pay other government expenses. Furthermore, the interest and retirement of the trust fund bonds will have to be paid out of general tax funds, mainly income tax funds. This is deficit financing and a dangerous national disease.

Is social security really insurance? Propaganda to enlarge the scope and payments of social security is tremendous. The public reads numerous booklets and is much impressed by the terms retirement and disability insurance payments or survivors insurance payments.

Social Security is Not Insurance

The word insurance has sold the idea of social security to thousands of people. I would like to point out that social security is not insurance. The premiums exacted are not voluntary; they are compulsory. The benefits are not stable. They are liable to go up or down, as the Congress wishes.

Why should the proponents of social security want the American public to think of social security as insurance? Can you think of a better way to sell a socialistic scheme of compulsory taxation to a traditionally independent and democratic people than to make its title and terminology in the people's minds the same as insurance, one of our oldest and most honored stable institutions?

Inasmuch as social security is not a written contract with the individual and does not cover a specified risk, nor is the premium proportioned to the risk involved, social security is not insurance as we know it. There are no specific guaranteed rates nor are there any specific guaranteed benefits, as both rates and benefits are dependent on legislation now and in the future.

The premium on insurance is a guaranteed premium; this is not so with social security. It is interesting that all of those people covered by social security could have obtained better coverage at a lower rate had they gone to a private insurance carrier.

When the government provides something to one group for less, then part of the cost must

be paid by some other group. Obviously succeeding generations will have to pay this debt through higher social security taxes or income taxes. A very good reason for the easy expansion of the federal benefit system lies in the fact that the tax burden falls very lightly on the present generation of workers and voters.

Phoney Trust Fund

It does seem somewhat ridiculous and selfish to have the present generation of workers who constitute the majority of the voters today, voting larger and larger benefits for themselves while the real cost of the scheme is deferred to the workers of the next generation in increased taxes of all kinds. Our taxes are too high now. They will be increased faster than the advocates of social security will admit, because the trust fund is phony and not on a pay as you go basis. The already promised benefits and greater promises to come can only mean increased taxes in the near future.

Of further interest in the tax situation is the proposed 23rd Amendment to the Constitution which would repeal the income tax law—outlaw foreign aid and forbid the government from entering into any kind of private enterprise.

This proposal is not meant as a joke. Here are some unbelievable figures: The federal government is operating at least 500 full-fledged corporations that operate at an annual loss of 25 billion dollars, which must be made up in taxes. If these corporations were sold for 50 billion (this is about 1/4 of their assessed valuation) and this money applied to the national debt, it would reduce interest payments by about 1 1/3 billion a year.

A Vicious Formula

On the basis of investigation it would appear that the income tax law has become a vicious formula for seizing private wealth and putting it to use to compete with the people that provide it. As to what the future holds . . . Mr. Morrison puts it bluntly, "Until Americans find the guts to call a halt to such demands and take care of themselves instead of forcing the government to assume such burdens the trend will only go up."

Freedom is important to me. I do not want my children or grandchildren to live in a society where government is the master and the people are the slaves. After evaluating our present problem, I have come to the conclusion that whether

Continued on page 68

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in more than 750 published clinical studies

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- 1 simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
- 2 no cumulative effects, thus no need for difficult dosage readjustments
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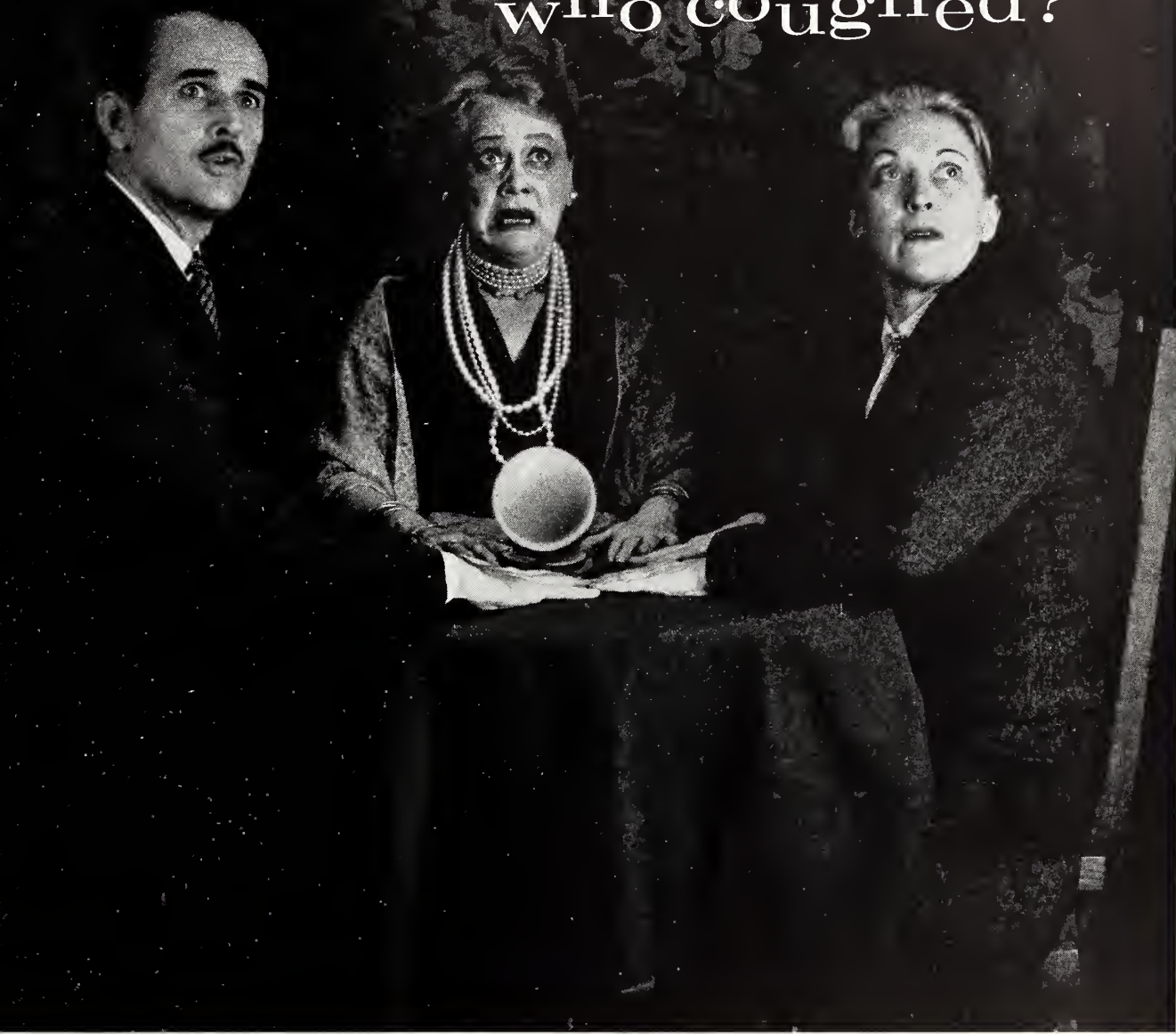
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*cough sedative / antihistamine
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- relieves cough and associated symptoms in 15-20 minutes
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Each teaspoonful (5 cc.) of HYCOMINE[®] Syrup contains:
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Dihydrocodeinone Bitartrate	5 mg.	} 6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	

Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.



Literature on request

ENDO LABORATORIES
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56 Hoosier Physicians Attend AMA Session; House of Delegates Actions Summarized

Fifty-six Hoosier physicians were among those registered at the 14th Clinical Meeting of the AMA in Washington, Nov. 28-Dec. 1.

They included Drs. Paul Alvarez, Gary; Charles R. Alvey, Muncie; Theodore D. Arlook, Elkhart; Leslie M. Baker, Aurora; Lester D. Bibler, Indianapolis; Robert M. Brown, Marion; Stanley W. Burwell, Muncie; John O. Carter, Hobart and William B. Challman, Mt. Vernon.

Drs. Stanley M. Chernish, Indianapolis; J. A. Creek, Bloomington; William D. Dannacher, Wabash; Max D. Davis, Evansville; Ralph W. Dreyer, Richmond; A. L. Fipp, Rome City; John Farquhar, Fort Wayne; S. N. Gellis, Indianapolis; James N. Hampton, Argos; John B. Hickam, Indianapolis; Carl M. Hostetler, Goshen; W. H. Howard, Hammond; Lester H. Hoyt, Indianapolis and Arlington M. Hudson, Connersville.

Drs. Jerome M. Johnson, Palmyra; Francis L. Land, Fort Wayne; James C. Lee, Terre Haute; Richard J. Manner, Evansville; J. M. Mass, Indianapolis; William M. Matthews, Indianapolis; William L. Mattison, Crane; Robert M. Maurer, Brazil; Frank J. McGue, Michigan City; Edward C. McKeon, Evansville; Robert D. Meiser, Huntington; Joseph F. Milan, Bloomington; Hugh A. Miller, Elkhart; John M. Miller, Bloomington; Lall G. Montgomery, Muncie; Harold C. Ochsner, Indianapolis.

Drs. Guy A. Owsley, Hartford City; F. Bruce Peck, Indianapolis; W. L. Portteus, Franklin; L. F. Rittelmeyer, Evansville; James S. Robertson, Plymouth; James B. Ross, Bloomington; Wendall C. Stover, Boonville; Milton Tepfer, Indianapolis; M. J. Thorton, South Bend; Harry Voyles, New Albany; Charles I. Weirich, Butler; Albert E. Weiss, Michigan City; Ernest W. Weiss, Indianapolis; Nelson A. Wolfe, New Albany; Don E. Wood, Indianapolis; H. J. Zimner, Mishawaka.



ISMA members entertained in their hospitality room in the Sheraton Park Hotel for the Chinese ambassador. Pictured here is Dr. Guy A. Owsley, ISMA president, Dr. W. B. Challman, Mt. Vernon; Mrs. Frank Tao and Mr. Tao, who is press attache to the ambassador.

House Actions

A scholarship and loan program for medical students, the status of foreign medical graduates, an AMA membership dues increase, the expansion of voluntary health insurance, health care for the aged and new developments in polio vaccine were among the major subjects acted upon at the American Medical Association's Fourteenth Clinical Meeting held in Washington, D. C., Nov. 28-Dec. 1.

Named as 1960 General Practitioner of the Year was 44-year-old Dr. James T. Cook of Marianna, Fla., who was selected for his dedication to both medical practice and service to the community. Dr. Cook is the 14th recipient of the award.

Speaking at the Monday opening session, Dr. E. Vincent Askey of Los Angeles, AMA President, called upon the delegates to support not only existing AMA programs but also expansion of new programs necessary to meet the challenges of society. Dr. Askey assured the new

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HOOSIER PHYSICIANS

Continued

administration in Washington of cooperation whenever and wherever possible but emphasized that the AMA will not change its policies merely for the sake of conformity.

Total registration reached 8,170, made up of 3,940 physicians and 4,239 guests.

Scholarship and Loan Program

The House of Delegates approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals, and also urged that there shall be local participation in the program at the state and county level. In commenting on the two-part program, the House approved the following statement by the reference committee:

"This proposed program will provide concrete evidence of the American Medical Association's sincere desire to attract increasing numbers of well qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designed to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this association's belief in individual responsibility."

Foreign Medical Graduates

Meeting the problem of foreign medical graduates, the House of Delegates adopted a report which included the following statement:

"In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such

programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the non-certified foreign physician the opportunity to take the April, 1961, Educational Council for Foreign Medical Graduates examination."

AMA Dues Increase

The House approved a Board of Trustees report which announced that a dues increase would be recommended at the annual meeting in June 1961. The report indicated that the amount would be not less than \$10 and not more than \$25 to be effective Jan. 1, 1962. The Reference Committee asked the Board to consider an increase in the annual dues of \$20.00, to be implemented over a period of two years: \$10.00 on January 1, 1962, and \$10.00 additional on Jan. 1, 1963.

The House suggested that these funds be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level.

Voluntary Health Insurance

In place of a Board of Trustees report and three resolutions, the House adopted the following substitute resolutions:

"WHEREAS, It has been widely recognized that voluntary health insurance is the primary alternative to a compulsory governmental program; and

"WHEREAS, The public has shown its confidence in this voluntary system; and

"WHEREAS, Current social, political and economic developments compel a new and re-

Continued on page 76

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Friedman, A. P., and Merritt, H. H.: J.A.M.A. 163:1111 (Mar. 30) 1957.

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HOOSIER PHYSICIANS

Continued from page 72

vitalized effort to make voluntary health insurance successful; and

"WHEREAS, The American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

"RESOLVED, that the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary, non-profit prepayment concept to provide health care for the American people; and be it further

"RESOLVED, that similar leadership be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

"RESOLVED, That, where feasible, efforts be made to cooperate with representatives of other types of medical care plans, other professional groups, and representatives of industry, labor and the public at large."

Health Care for the Aged

The House reaffirmed the Association's support of the Kerr-Mills Bill, which was passed last summer, and its opposition to any legislation involving the use of the OASDI mechanism for medical aid to the aged. The delegates also urged all state and local medical societies to cooperate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

In connection with health care for the aged, the House suggested further experimentation in home care programs, homemaker services and visiting nurse services. The delegates also recommended an increased emphasis at all levels of medical education on the new challenges being presented to physicians in the health care of older persons.

Polio Vaccine

The House agreed with a Board of Trustees report which said:

"In view of the fact that oral polio vaccine will not be generally available in sufficient quantity in 1961 for any large scale immunizing effort, the Board of Trustees of the AMA strongly recommends that the medical profession encourage the widest possible use of the Salk vaccine for the prevention of poliomyelitis. The Salk vaccine has been proved to be effective and since there are still many segments of the population not immunized against poliomyelitis every effort should be made to encourage the general public to take advantage of the Salk vaccine without delay."

The Board report was amended to suggest that a proper committee be established by the AMA to study the problems involved in administration of the new oral polio vaccine and to establish guides for physicians to follow when they are approached by various groups and asked for their support in administering oral polio vaccine.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Approved continuing study and periodic re-evaluation of the trend toward locating *physician's offices* in or adjacent to hospitals;

Directed the Committee on Medical Care for Industrial Workers to carry out its duties as previously instructed and to prepare guides for physician relationships with *medical care plans* in conformity with the clear policies already laid down by the House of Delegates;

Approved a set of guides relating to drug expenditures for *welfare recipients*;

Asked the Board of Trustees to study the question of blood replacement responsibility and also the matter of establishing health insurance fee schedules for *surgical assistants*;

Urged the Board to make every effort to reduce the number of physicians who are non-dues-paying members and approved a three-year study report on the relationships of *physicians not-in-private-practice* to organized medicine;

Requested the Board to present a completed *retirement and disability* insurance program for AMA members at the June, 1961, meeting, and

Agreed that the *General Practitioner of the Year Award* should be continued as at present.



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NASAL SOLUTIONS AND SPRAYS

Delivered before the House of Delegates of the American Medical Association, Monday, Nov. 28, 1960, Sheraton-Park Hotel, Washington, D. C.

House of Delegates Address

E. VINCENT ASKEY, M.D.

President, American Medical Association

IT IS ALWAYS an inspiration to be in Washington—the capital city that represents all Americans.

And it is always appropriate for a national association to hold a national meeting here. For us in the American Medical Association to assemble here now is especially timely and significant.

We are here again for two purposes—two goals for which our Association was founded 114 years ago and for which our Association today still works for with might and conviction. These are simply: To promote the science and art of medicine and the betterment of the public health.

We have been dedicated to these aims in the past and we are dedicated to them now. Nothing shall deter us. And we shall pursue them along many pathways—scientific, economic, legislative and political.

Washington is definitely an outstanding medical center in our nation, and therefore it is fitting that our Association has come here to pursue the latest in the science and art of medicine.

Washington also is the nation's legislative fountainhead, and therefore the laws enacted here affect the political and economic future of all citizens.

Medical Care for Citizens

It is fitting, therefore, that our Association is here, at this time, to make our position clear once again on certain legislative proposals dealing with the health and medical care of our citizens.

In recent years the American Medical Association has been particularly interested in developing the specifics of a sound approach to the health service and facilities needed for the aged. The Congress also has studied and debated the issue of health care insurance for the aged during recent years.

We were pleased when Congress passed and sent to the White House a voluntary, federal-state plan of helping elderly persons who need help, meet their medical and hospital costs.

Both the defeat (51-44) in the Senate of the Anderson amendment for a health care program utilizing the social security mechanism and the victory of the Mills-Kerr bill were a culmination of months of intensive work by the state and local medical societies, by individual physicians, by strong allies in business and industry and by many dedicated Congressmen and Senators of both parties.

Your AMA supported to the fullest the broad proposal of federal-state matching funds to provide care for the needy and the near-needy aged because it believed the program would provide the best possible medical care for our older citizens.

Despite the fact that this sound, far-reaching legislation was passed and was signed into law, the proponents of the Social Security approach elected to introduce the issue into the recent national political campaign. They did this even though the health care measure voted by Congress provided hundreds of millions of dollars to finance health care costs of those elderly persons who needed it.

I am sure many of you were disquieted to

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DR. ASKEY ADDRESS

Continued

learn that the electoral college majority went to the presidential candidate whose party's platform backed the social security approach.

The President-Elect will bring to this city and to our nation a new administration in less than two months. With the executive branch of the government in his control he undoubtedly will attempt to carry out certain promises he made in the field of medical care for the aged. He may try to do that which he could not do with supposed control of the legislative branch of the government last August.

As a national association of physicians dedicated to high medical principles and ethics and to democratic ideals, I can assure this new administration that the medical profession has great respect for the office of the President of the United States and shall cooperate with it whenever and wherever possible.

Will Not Alter Policies

However, this does not mean that the American Medical Association intends to change its basic policies merely to conform to those of the new administration or any segments of either political party.

We shall propose and promote our views on the betterment of the public health—for all age groups—regardless of friends and foes. For us the best possible medical care and the principle of the freedom of the individual—both doctor and patient—are far more important than political expediency.

While our profession clearly may face a hard struggle in the 87th Congress on the issue of medical aid for the aged under Social Security, there is no ground for defeatism!

Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained.

I remind you that medicine has many friends in both parties in Congress today. In fact, I would say that in this year's national elections we have increased that number in both the House and Senate.

Furthermore, we can take heart in the fact that a number of legislators who strongly endorsed the social security approach to medical

care for the aged will not be returning to Washington for the 87th session of Congress.

Several other factors also should bolster our confidence.

1. Although an all-out drive was conducted to purge large numbers of conservative Democrats and Republicans, this campaign failed—with one or two exceptions.

2. The President-Elect's margin of victory is so narrow that it would be difficult for even the most zealous adherent to consider this a mandate for a massive program of social change.

3. The results make it dramatically evident that a powerful and articulate body of conservative opinion exists in this country.

No, defeatism has no place in our ranks as we prepare to fight new versions of the kind of proposed legislation we defeated in the last session of Congress.

Our position is right. We are together on this issue. Our allies have fought, and will fight, side by side with us. And our friends in Congress—in both parties—can be expected to battle once again to keep the sound legislation now in effect, and to maintain the principle of individual initiative, local determination, local administration and local control.

We believe in the Mills-Kerr program because it is operated at the state, rather than the federal, level. The individual states will decide who is eligible for help and how much and what type of help they will receive. As this House of Delegates recommended in June:

"The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control," and the federal government has responsibility for care "only in conjunction with the other levels of government."

Potentially, this act can provide for better assistance in meeting medical expenses for our older citizens better than any of the programs proposed as appendages to the Old Age and Survivors insurance section of the Social Security Act. I am talking now not only about the level of government at which the programs are administered, but also about who is helped and how much he is helped.

We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, prac-

tically as well as potentially, solve the problem of medical care for the aged.

The medical profession has testified that the aged can best be helped through locally administered programs, aimed at those in real need. It has testified in favor of individual initiative, bolstered by voluntary health insurance and community and state programs for those unable to meet their own costs. It has strongly supported the Mills-Kerr bill.

Congress in its wisdom has followed this prescription. If we don't make the medicine work and if the patient doesn't show signs of improvement, our professional advice may be shown much less respect in the future.

New Bill Requires Leadership

I strongly urge this House to charge all county and state medical associations with the responsibility of providing the medical leadership necessary to implement the Mills-Kerr bill as rapidly as possible.

Of course, physicians should definitely give the new administration their wholehearted support in all programs that will preserve peace, representative government, free enterprise, fiscal solvency and the stability of the dollar, and that will truly promote the well-being of all the American people.

Like the President-Elect, we too oppose vigorously job discrimination because of age, and we definitely favor more jobs for the aged. Also our Association supports a brick-and-mortar plan for medical education. Here the profession most emphatically states that there is sufficient need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools to justify a one-time expenditure of federal funds on a matching basis.

Furthermore, we too favor the best possible medical research on major diseases. However, mere "stepping up" of such research by using more money is not necessarily going to produce the desired results. If money were the only necessary ingredient for the conquest of heart disease, cancer, the common cold and other illnesses, we undoubtedly would have had cures, vaccines and successful treatments long ago.

Helter-skelter spending will not give us medical research results; however, good planning, talented scientists, top-notch facilities and adequate funds perhaps may do the job.

Proposals Aren't New

I submit to you that after having reviewed the health and medical programs of political parties and political candidates, there is little—if anything—unusually new in the proposals made in recent months.

Medical care for the aged, medical research, medical education and more physicians, health insurance, rehabilitation and mental health—these topics are familiar to all of us, for we are constantly studying them and improving upon them. Efforts to deal politically with any one of them are not going to bring forth a magic solution.

Remember, our nation's medical strength and growth have not come from the federal government and tax spending. As always our medical strength and growth have come from creativeness, competitiveness, initiative, responsibility and dedication of the men and women of medicine, science, and industry. These are the factors we have relied upon to attain the greatest medical heights in the world.

What folly it would be to bench this superb combination and replace it with federal controls, domination, red tape and a cornucopia of tax dollars.

From bold plans in voluntary health insurance to splendid hospitals and clinics; from incredible new medical instruments to wonder-working vaccines; from electronic medical marvels to great surgical feats; from revolutionary drugs to rehabilitative aids to make a man whole again—these are some of the advances all of us have seen delivered to the American people by private, free enterprise.

And I take particular pride in the role our Association has played in each of these.

Furthermore, every AMA member should be enthusiastic and vocal about the many special projects launched by your Association in behalf of the public health in just the last six months or so. These programs too will undoubtedly have a real impact on the health of many Americans.

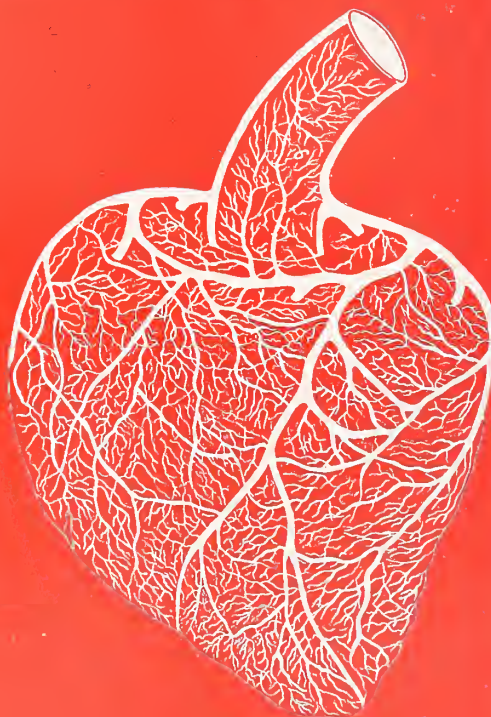
Specifically, I refer to such far-reaching work as:

—The five-year study on infant mortality and morbidity with the aim of preventing and reducing deaths and defects of babies by the thousands in this decade.

Continued on page 88

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*Clark, T. E., in press.

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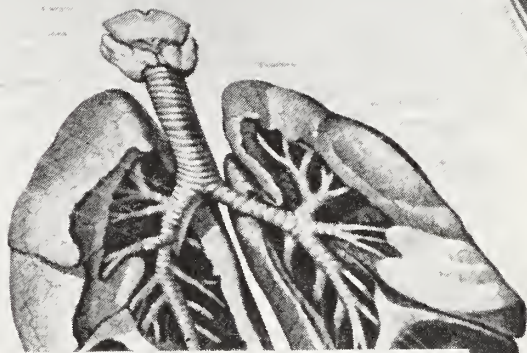
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DR. ASKEY ADDRESS

Continued

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—Our continuous efforts to add life to the added years of old age and to improve the health care of our elderly citizens.

—Our safety campaign to reduce traffic deaths significantly via seat belts and new laws on safety devices in new automobiles.

—Our medical recruitment program to draw a greater quantity and quality of applicants to the nation's medical schools, and thus help to insure our nation of an adequate supply of well-trained physicians.

—Our new program to provide assistance in the medical missionary work being done by all religious denominations overseas.

—Our poison control campaign to prevent the death and injury of thousands of children and adults.

I could continue with this impressive listing of excellent programs.

Because of these specific projects we have gained a momentum that we ought not to lose.

Because of the increasing public interest in medicine and good health, there is a definite need for the AMA to keep pace with every new advancement in the scientific and socio-economic medical field. We must not only keep pace but also we must provide the leadership in making the advantages of this program available to all Americans.

This House of Delegates, the Board of Trustees, the AMA councils and committees, and the staff have realized this in recent years, and have suggested interesting significant ways for the AMA to perform its public services and its continuing education for practicing physicians.

But good works require money. And in modern times they are increasingly expensive because of medicine's complexities.

I wish that each of you could have sat in on the recent sessions of the Board of Trustees as it deliberated on the 1961 budget. While no one wanted to drop or discourage projects, I must report that budget balancing made it necessary to curtail and to delay many very important and vital programs.

Responsibilities Grow

As the nation's most resourceful medical organization, our responsibilities to a growing nation intensely interested in health have multiplied. As members of this Association, I believe that we should support not only existing programs but also expansion of these and other new programs which must be initiated to meet the challenges of our society.

We now are on a massive offensive against disease and unnecessary death and injury, and for the betterment of the public's health.

Additional funds to strengthen this offensive are needed, and I submit to this House of Delegates that our individual responsibility is to accept a larger financial share in the best possible AMA program for the public and for ourselves.

Furthermore, it is incumbent upon each of us, each of our state medical associations, and each of our county societies to bring into our memberships all eligible physicians who are not now participating in our efforts to promote the art and science of medicine and the betterment of the public health.

Now only one out of 10 physicians who, in my opinion, should be in the AMA, does not belong to the Association. We must actively seek to add all those currently outside our ranks so that we may truly represent the strongest, most united front possible as we face our responsibilities to the American people.

In unity I believe that we can find greater wisdom, greater potential, greater strength and greater perseverance. And thus as a unified profession, we can prove to be the nation's, and the world's, most potent influence for the best possible health for all the people. ◀

Report on Experiences of Recipients of Patient Care

MRS. MONTGOMERY S. LEWIS*

Indianapolis

IN THE LAST five years, I have had a taste of today's hospitals in larger doses than I ever would have anticipated. I have been in twice myself, and two other members of my family have had serious experiences with which I have been closely associated. Each time, we have shared the room with a stream of other people and I have often been deeply concerned for them, too, and their reactions to their problems and care.

With my background on the Joint Committee on Improvement of Patient Care in Indiana, I am trying to view in an objective fashion what seem to me to be "gaps" or lacks in service. Earlier, I admit, I have been both emotionally disturbed and very critical.

You on the committee who are doctors rightly think first of the highly technical phases of the care and cure of the patient. I have never had reason to criticize the high degree of service during the peak hours of the emergency which brought me, or the others whom I mentioned, into the hospital. The physician, the surgeon, the hospital staff, all seem closely coordinated and tuned to the needs of the patient. But when that moment passes and the doctor is not so often on hand, there is a tremendous "let-down." There may still be serious physical problems to be met, but there seems to be no one person in the hospital who gives him more than cursory, segmented, impersonal care.

Earlier, the doctor was the understanding friend and manager. Who takes that place? In

my experience, no intern or supervising nurse seems to have inherited that mantle. The patient often finds himself in the position of seeming to have to direct his own care and healing program. So, service drags; and, I am sure, that for many people it prolongs the stay in the hospital and is expensive for all concerned—the patient, the family, Blue Cross and the hospital staff.

Little Sense of Continuity

Nowadays we talk about "The Team" as the basic pattern of service to the patient, and therein may be the trouble. So many people serve the patient, each a person of good will, but interested and knowledgeable about only a small segment of the needs of the individual in any given 24 hours or longer. The result is that the patient feels little sense of continuity of care, backed by any real understanding of himself, as a whole person, and of his particular physical problem and needs. I have heard hospital people say that patients should be mature enough to understand the difficulties under which modern hospital personnel labor and to accept the situation gracefully.

However, none of us go to the hospital when we are well and able to manage our own lives. Once there, we are so wholly dependent upon others! Little effort, or none, is made to orient the new patient even if he is stable enough to listen or to understand what service to expect, how to ask for it or how much he can be allowed to do or is supposed to do for himself. If comparatively helpless, this often becomes very disturbing.

* Presented at a meeting of the Joint Committee on Improvement of Patient Care in Indiana, Jan 20, 1960.

PATIENT CARE

Continued

Service is often slow, and carelessly and forgetfully passed on from one helper to another. Soon, the patient begins to feel that he is no longer a whole person, seen as such, and cared for as such, with anyone on hand or in the background who viewed him from a real and responsible knowledge of the program which would make him well. The hospital seems to be a gigantic jigsaw puzzle which many people are trying to put together. But why? For the care of the patient? Or is he simply one of the little pieces which are being shifted about?

In surgical cases, the disturbance and discomfort of the patient is, of course, often acute. To have a stream of different people answer a bell, who have no other answer except to say, "I will see if I can get a pain pill for you," gives no sense of real help and support. Nights, of course, are particularly hideous. Pain seems more acute, hours are interminably long. Standard orders for night care seem to be most limited in character and do not reflect the progress of modern medicine. Nurses and other attend-

ants move quietly and seem almost like automations, offering little of relaxation either by manner or medication.

I wish more doctors could have, themselves, a period of hospital night care to endure. Could not the staff doctors of each hospital establish a committee to reconsider, even to research, night medication, etc.?

Also, do the doctors sufficiently consider and indicate to the nursing personnel and/or to an intern the 24-hour care of the patient? This is a joint responsibility not sufficiently explored—in my humble opinion—in this day of specialization and much divided responsibilities.

Patterns of work and behavior become easily fixed, and we consider them as ends in themselves and our goals. I think they need constant reviewing in the light of the individual patients and their needs. If there is such research, and we divide it into categories, why not orient it toward the patient, not toward the disciplines? First, the technical care of the patient; secondly, his physical care, such as cleanliness, food, etc.; and thirdly, his psychological response to the care that is being given to him, or the lack of it.

This third consideration should be in relation to every patient, not to just the ones who seem querulous or disturbed. The "good" patients should not be the ones who are willing to simmer and ask little. The ones who wind up their dynamos so that their program of recovery moves forward should not have to feel apologetic as nuisances; instead, they are helping themselves back to normal activity and rehabilitation and need understanding, helpful guidance.

Certainly, this is all a joint responsibility; cutting across all groups in the hospital with changes that center in the patient, not in the groups of personnel. ◀

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Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

A parson diminutive in size and with hair of the most fiery hue, officiated on Sunday in a remote mining village in Britain.

The old-fashioned pulpit had a high desk, over which the parson's red head was hardly visible.

This was too much for a burly miner who was seated immediately under the pulpit and who, when he heard the text, "I am the light of the world," exclaimed aloud to the clerk; "Push him up higher, mate; don't let him burn in his socket."—*Quote*, Oct. 30, 1960.



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Development of Blue Cross and Blue Shield Benefit Programs

(One of a series prepared by Blue Cross-Blue Shield)

Since organization, both Blue Cross and Blue Shield have made a concentrated effort to broaden the health care benefits available to the people of Indiana. Since membership fees directly relate to the scope of benefits, one way of indicating the progress that has been made is to show the highest and lowest Blue Cross and Blue Shield membership fees in effect from 1946 to 1959. The chart below is a quick history of the development of benefits by the two plans. The fees shown are for benefit programs actually in effect, and being paid for by some account during the year indicated. In all cases, the fee shown is for family coverage.

Blue Cross		
Year	Fee For High	Fee For Low
1946	\$ 3.00	\$2.00
1950	4.00	2.50
1953	6.20	4.40
1956	6.55	5.10
1959	10.64	6.25

Blue Shield		
Year	Fee For High	Fee For Low
1946	\$2.25	\$2.00
1950	2.50	2.00
1953	6.70	2.00
1956	6.70	2.40
1959	7.20	2.40

Back in 1946, the year Blue Shield was organized, the highest Blue Cross fee was \$3.00 while the lowest was \$2.00; for Blue Shield the highest was \$2.25 and the lowest \$2.00. By 1959, the highest Blue Cross fee was \$10.64, and the lowest \$6.25; the highest Blue Shield fee was \$7.20 and the lowest \$2.40. During the 13-year period Blue Cross increased its membership fees 255% for its best available program, while Blue Shield made an increase of 220%. During the same period the fee for the lowest Blue Shield program increased from \$2.00 to \$2.40. This additional 40 cents represents anesthesia benefits which were added to all Blue Shield surgical schedules in 1956.

Another way to show the development of Blue Shield benefit programs is to list the changes in such programs as they occurred in one specific

account. The table below shows the changes in benefits for one major account in Indiana which covers more than 100,000 people on a statewide basis.

History of Blue Shield Benefits			
Year	Item	% Increase In Benefits	Payment Increase*
1946	Base Program—Standard		
	Surgical and Obstetrical		100.0
1948	Increased allowances in		
	Standard program	8.6	108.6
1950	More increased allowances		
	in Standard program	2.2	111.0
1953	More increased allowances		
	in Standard program	.9	111.9
1954	Added In-Hospital Medical		
	(30 days at \$3.00)	11.1	124.3
1954	Increased In-Hospital		
	Medical \$10.00 first day	5.2	130.8
1955	Added Anesthesia A	8.0	141.3
1955	Changed to Preferred		
	Series with Anesthesia B	30.0	183.6
1957	Changed to 20%		
	Anesthesia	15.0	211.0
1959	Increased In-Hospital		
	Medical to 120 days	4.0	219.4
1959	Added Diagnostic X-ray		
	and Pathology	15.0	252.3

* This column shows the effect of added benefits on payments to doctors in terms of ratio to the 1946 base.

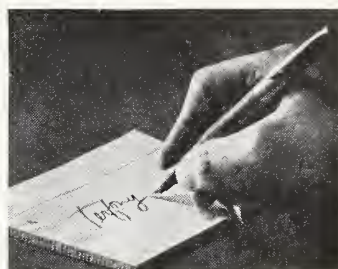
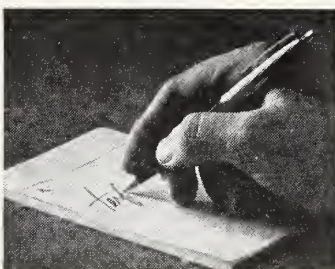
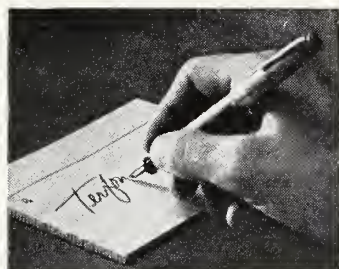
The above table indicates that Blue Shield is now paying the members of this account more than two and one-half times the 1946 payments, for benefits which have been added and schedules which have been increased since that year.

Both tables illustrate graphically the development of broader programs, and show the actual effect of this availability in terms of the benefit history of one account.

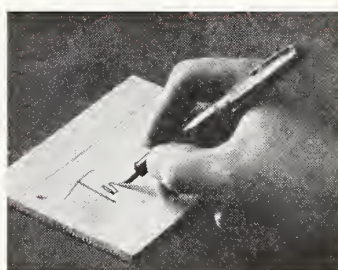
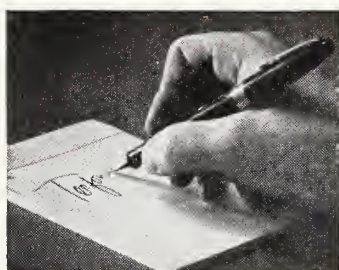
With the guidance of Indiana doctors, Blue Shield will continue to keep up with the changing conditions of medical practice, developing and selling benefit programs that meet the real needs of the people of Indiana.

W. C. Huddleston

Public Relations Division ◀



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*All doctors' offices, hospitals
close as 38 members undertake
sponsorship of enormous display.*

Society Hosts to Nearly 5,000 Teenagers For Medical Sciences Exhibit

By Sara M. Snyder

Cover Photo by R. J. Amick

THE 38 members of a southern Indiana county medical society, realizing a growing problem in the lack of adequate sources for medical and allied professions to draw from, decided to take action not long ago.

They ended up closing all offices and local hospitals—except for emergencies—to be hosts for a two-day medical sciences exhibition attended by nearly 5,000 southern Indiana teenagers.

Held at the Columbus, Ind., school gymnasium and sponsored in its entirety by the Bartholomew-Brown Medical Society, the event is thought to be the most extensive ever produced in the U. S. on a locally-sponsored basis. It featured nearly 50 displays and was widely publicized in area newspapers and on TV and radio.

Several months ago, an Indiana University official had discussed at a district medical meet-

ing the growing problem of insuring adequate sources for tomorrow's doctors. All 38 members of the Bartholomew-Brown Medical Society took the question to heart, and under the direction of Dr. Robert Reid, young Columbus general practitioner, they conceived the idea of a science exhibition to stimulate interest among local teenagers.

The group found that junior high and high school youngsters know very little about science careers that will be available to them in the future. Although education is geared more and more toward science, pupils are not oriented toward college science courses and career possibilities in medical and allied fields.

Dr. Reid's idea "grew like Topsy." What was originally planned for a local project in the end included students from throughout the southern



MEDICAL RECORD personnel from the Bartholomew County Hospital explained the nature of their work at a display which included the actual materials with which they work.



MANY FUTURE PHYSICIANS were intrigued by the local hospital's radiology exhibit. The display was attended by hospital personnel and included films which they explained by use of a skeleton.

—R. J. Amick



THE CLINICAL LABORATORY exhibit, attended by medical technicians, was a feature attraction. Hospital personnel were on hand to type blood for the youngsters.

—R. J. Amick



THIS YOUNG MAN got a chance to work with a dental drill at an exhibit concerning clinical dentistry.

—R. J. Amick

counties of Indiana, brought in on busses by their teachers.

In the evenings, the display was open to the general public. It was financed entirely by the county society. Exhibitors, consisting of allied medical sciences groups on a state and local level, footed only the bill for bringing in their exhibits.

Typical Surgical Procedure

A highlight was the mock operation four times each day, performed by society members and nurses in a surgical amphitheatre set up as a typical operating room. It included all equipment—operating table, lamps, anesthetic machine, intermittent positive pressure breathing apparatus, cardiac stimulator, cardioscope, instrument table and instruments, x-ray view box and blood pressure apparatus.

The entire procedure, from preanesthetic stage to the recovery room, was moderated by a physician. It was the first opportunity for many of the youngsters to gain an understanding of what takes place in surgery—the personnel required, preparation, equipment, etc.

Other exhibits ranged from a missile nose cone from the Titan ICBM to the maternity care department of a typical hospital. The Red Cross operated a blood bank.

Displays were the combined efforts of the local dentists, veterinarians, druggists, nurses, health agencies, medical technologists, specialty groups, hospital personnel, and x-ray technicians. County society members were on hand at all times as official hosts and to answer questions.

Also exhibited was material from Indiana, Butler and Purdue universities, pharmaceutical house projects, medical and surgical supply house products, nearly all state voluntary health agencies, the Board of Health and all branches of the Armed Forces. Members of the auxiliary and the medical assistants were on hand to help.

In meeting and talking to the youngsters at the exhibit, one could realize the reason for the tremendous enthusiasm on the part of each society member. Without exception, the teenagers told this reporter that their high school counseling programs were "mostly for the bad kids." Very few had experienced any type of career or college counseling during their schooling. They were enthused and thankful. Many said that talking to persons of different professions was helpful, and that they understood so much better what a science career was all about.

One youngster commented that he "always thinks of so many questions later." But the

RED CROSS blood bank personnel explained their work as they accepted donations from students attending the exhibition.



DR. ROBERT REID, general chairman of the project, confers with his nurse, who was one of a group of nurses and medical assistants helping with the exhibition.



—R. J. Amick

society is one jump ahead of this problem. The exhibit itself was merely a kickoff for a year-long program.

Teenagers attending the exhibit signed "interest cards" which were sorted and sent to their local societies for the purpose of setting up counseling programs, with the cooperation of Indiana colleges.

In general, these programs will consist of an orientation session to which parents are invited. The groups then will be divided as to their spe-

cific interests, and discussion programs planned on a monthly basis.

In total the project represented hours of planning and work on the part of society members. For 38 persons, it was a tremendous undertaking. The initial response was most gratifying; however, it will be impossible to evaluate exactly what was gained. Most certainly, they assured the public that they are conscious of a growing problem and that they are aggressively concerned about it. ◀

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You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

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Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



Hill-Burton Grant Approved For Porter Hospital Project

The Department of Health, Education and Welfare reports that during the months of August, September and October, status of all Hill-Burton grants for Indiana included one project approved during October at the Porter Memorial Hospital, Valparaiso. Estimated total cost is \$1,759,485, with a \$187,409 federal share. It will provide 96 additional beds.

For the three months, 68 projects were completed and in operation, at a total cost of \$72,706,689, including a federal contribution of \$23,828,304, and supplying 3166 additional beds.

As of Oct. 31, 27 projects at a total cost of \$32,507,193, including a \$8,661,248 federal contribution and supplying 1137 additional beds were under construction.

Approved, but not yet under construction were two projects, costing \$2,541,769, including a \$416,087 federal contribution and designed to supply 96 additional beds.

Ob-Gyn Part II Exam Set

The American Board of Obstetrics and Gynecology announces Part II oral and clinical examinations April 8-15 at the Edgewater Beach Hotel, Chicago. Candidates who participated in Part I examinations will be notified of eligibility.

SIX NEW FELLOWSHIPS ANNOUNCED FOR OPHTHALMOLOGY RESIDENTS

Six additional Fellowships for Residents in Ophthalmology, to be awarded July 1, 1961, have been announced by the Guild of Prescription Opticians of America, Inc. Applications for these Fellowships must be received by May 15, 1961.

Each Fellowship is for a total of \$1,800, payable in monthly stipends over the period of a three-year residency. The grants are limited to Residencies at approved institutions where full three-year residencies are offered, but residencies which begin anytime during the calendar year are eligible. Application forms and covering information are available by writing to Fellowships, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

Indiana Chest Physicians Name Officers

Dr. Arvine G. Popplewell, Indianapolis, was elected president of the Indiana Chapter of the American College of Chest Physicians at its annual meeting at French Lick, Oct. 5.

Assisting him will be Drs. Francis W. Hare, Madison, vice president; and John V. Thompson, Indianapolis, secretary-treasurer.

V.A. Registers 710 Cases of Tuberculosis-like Disease

The Veterans Administration, since Jan. 1, 1960, has registered 710 cases of a tuberculosis-like disease which has come to the attention of physicians in the United States during recent years.

As yet the disease has no name more specific than "infections due to unclassified mycobacteria." Doctors are trying to learn more about the bacteria that cause it.

The infections closely simulate TB and usually affect the lungs.

Since the prevalence of the disease in this country is unknown, the VA undertook the task of compiling a case register from the agency's hospitals and clinics on a nationwide basis about a year ago. Thirty-two cases have been reported in Indiana.

The register will be used by the VA for evaluating treatment of these patients and developing new research approaches to the disease.

NEWS NOTES

Continued

PMA Names Dr. Coggeshall Winner of Annual Award

Dr. Lowell T. Coggeshall, vice president and Professor of Medicine at the University of Chicago and an alumnus of Indiana University School of Medicine, recently received the 1960 Pharmaceutical Manufacturers Association's Annual Award for outstanding basic contributions to medicine.

Dr. Coggeshall has attained an international reputation as an expert in tropical diseases and has supervised expansion of his University's medical education, hospital, clinical and research activities.

Presentation of the award was made at the PMA annual eastern regional meeting in New York City, Dec. 13, by Harry J. Loynd, president of Parke, Davis and Company and Chairman of the PMA Board of Directors.

Dr. Coggeshall first went to the University of Chicago as an intern 32 years ago. He was

named Dean of the division of biological sciences in 1947, and became vice president last April.

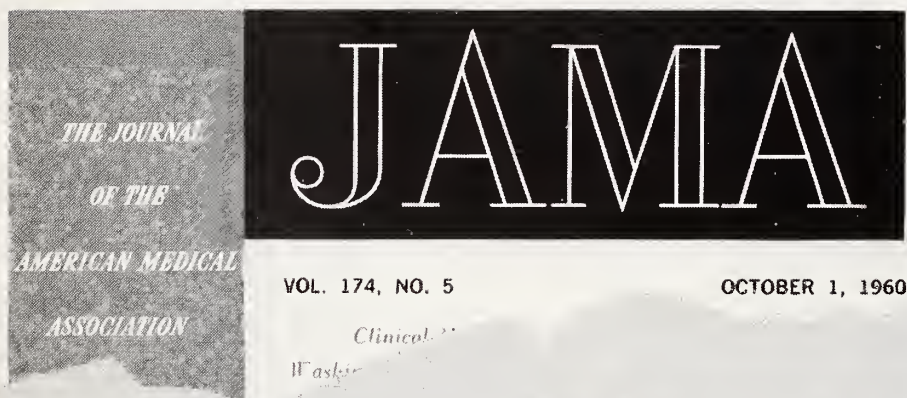
During World War II he served the military services in advisory and technical capacities, and more recently has held special posts with the federal Departments of State and Health, Education and Welfare. In 1956 he accompanied Vice President Nixon to Austria to survey medical relief needs of Hungarian refugees.

In Chicago, Dr. Coggeshall is a member of the Board of Health, chairman of the Citizens Advisory Committee to the Coroner of Cook County, and a member of the boards of directors of a number of medical and scientific institutions.

He is a past president of the American Cancer Society, the Association of American Medical Colleges and the American Foundation for Tropical Medicine, and a former special assistant to the Secretary of Health, Education and Welfare.

Internists Elect Officers

An Indianapolis physician, Dr. Arthur B. Richter, is the new president of the Indiana Society of Internal Medicine. Assisting him will be



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J.A.M.A.
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Drs. George Willison, Evansville, president-elect; Lowell H. Steen, Whiting, vice-president; Paul F. Tischer, Indianapolis, secretary-treasurer; and Stephen L. Johnson, Evansville, Ben Klatch, Lafayette and Sherman Egan, South Bend, executive council members.

U.S. Public Health Service Supports 150 Research Projects Through Cancer Institute

The U. S. Public Health Service through the National Cancer Institute is supporting approximately 150 research projects concerned with viruses as a possible cause of cancer.

In Indiana grants to Indiana University Foundation Research Division amount to \$26,846 on the subject of Mechanisms of Induction of Neoplastic Growth under J. Ashmore; \$14,322 on Proteins of Bacterial Viruses under D. Fraser; and \$20,513 for The Structure of Nucleic Acids from Human Tissues under M. E. Hodes. At the University of Notre Dame \$58,060 has been granted for the subject of Tumor Viruses in Germfree Animal Gnotobiotics under the supervision of T. G. Ward.

Emergency Stockpile Program Transferred

The national emergency medical stockpile program has been transferred to the Public Health Service. It was formerly under the Office of Civil and Defense Mobilization. The change is a part of the move toward mobilization readiness under the National Health Plan. The responsibility involves some \$200 million worth of medical supplies and equipment located in 33 warehouses throughout the country. Included are 1932 "packaged" 200-bed hospitals for civil defense emergency use.

Medical Tour to Depart Soon

An around-the-world medical tour by air and cruise ship for physicians and their families is scheduled to depart from New York Feb. 4.

In addition to sight-seeing, the itinerary includes visits to the Pasteur Institute, Paris; Allgemeine Krankenhaus and Pirquet Neues Klinik, Vienna; the medical school at Istanbul; the Medical center of Tel Aviv; American University Medical School at Beirut; and medical schools at Calcutta, Hong Kong and Hiroshima.

Continued

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1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1, 1960.

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NEWS NOTES

Continued

Cincinnati Industrial Health Institute Offers Industrial Medicine Fellowships

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in industrial medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

The three-year program leading to the degree of Doctor of Industrial Medicine satisfies the requirements for certification in Occupational

Medicine by the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in the field of industrial medicine. A third year is spent in residency in an industrial medical department or in some comparable organization.

Stipends for the first two years vary from \$3,000 to \$4,000, depending upon marital status. In the final or residency year the fellow is compensated by the organization in which he is completing his training.

Two other programs of study are offered to qualified applicants. A one-year course is available to applicants who wish to become candidates for the degree of Master of Science. In addition, a three-year academic program, leading to the degree of Doctor of Science, is available to those applicants who wish to pursue careers in teaching and research. A number of fellowship stipends are available to candidates in these programs also.

Requests for additional information should be addressed to the Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda Avenues, Cincinnati 19.

Dr. Charles O. Hamilton, South Bend physician, was recently elected assistant secretary of the American Society of Anesthesiologists at a New York meeting.

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Life Insurance Fund Grants \$31,350 to I.U. Study

The Life Insurance Medical Research Fund has announced a grant of \$31,350 to Indiana University School of Medicine for study of the behavior of retinal blood vessels of the human eye under the direction of Dr. John B. Hickam.

This is one of 120 research programs to which the sum of \$1,085,410 has been granted this year for study of heart disease. The fund has contributed more than \$12 million since 1945. Life Insurance Medical Research is supported by 138 life insurance companies of United States and Canada.

I.U. Medical School Lists Six Appointments

Six appointments to the Indiana University School of Medicine faculty were announced recently by Dean John D. VanNuys.

New appointees include Drs. Edgar E. Hurst, Jr., assistant professor of pathology; John Mealey, Jr., instructor in neurosurgery; Daniel E. Overack, instructor in anatomy; Robert M.

Palmer, instructor in orthopedic surgery; James J. Schaffer, instructor in pediatrics and Richard B. Schnute, instructor in medicine.

Drs. Burney and Bitner Take Offices In Association of Military Surgeons

Dr. Leroy Burney, Surgeon General of the U. S. Public Health Service and formerly Indiana State Health Commissioner, was recently elected president of the Association of Military Surgeons. Dr. Robert E. Bitner, a graduate of Indiana University School of Medicine, and recently retired from the U. S. Army was elected secretary of the organization. The next annual meeting will be held at the Mayflower Hotel, Washington, D. C., Nov. 6, 7 and 8, 1961. ◀

"Doc," said the old mountaineer, leading a gangling youth into the presence of the village medico, "I want you should fix up my son-in-law. I shot him in the leg yesterday and lamed him up a mite."

"Shame on you, shooting your own son-in-law!" scolded the doctor.

"Wal, Doc," rejoined the mountaineer, "he warn't my son-in-law when I shot him."

Quote, Oct. 1960

THE HARDING SANITARIUM

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For the Diagnosis and Treatment of Psychiatric Disorders
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Limited Facilities for the Aging

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VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.

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The activities of the Medical Department here at the Home Lawn Mineral Springs are held to sound medical and scientific standards as it works in close harmony with . . .

the department of hydro-therapy where only trained attendants are in charge of the famous mineral water baths and treatments

the department of electro-therapy completely outfitted with modern equipment and operated by an especially trained person

the department of X-ray, cardiograph, and laboratory supervised by competent and dependable operators

the department of food preparation for those requiring special diets supervised by a trained dietitian.

The Medical Department at Home Lawn Mineral Springs is equipped to care for certain types of rheumatism, arthritis, and allied conditions, as well as nutritional diseases, heart conditions, hypertension, gout, and diabetes.

Various types of mineral baths, as directed by the Medical Department, are highly beneficial in keeping your weight at the proper level according to your activity and time in life.

We in America, young and old, are now much more conscious than ever before as to the need of weight control for good health and a happier, longer life.

Treatment baths in the famous mineral waters here at Home Lawn Mineral Springs under medical direction, along with the health building program, have made Home Lawn known over a wide area of the nation, which justifies the slogan . . . "One of the three best known watering places in America."

HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. PITKIN, M.D., *Medical Director*

J. W. Gibbs, M.D., *Associate*

FUTURE MEETINGS, SEMINARS, COURSES

Chicago Ophthalmologists Plan Program for May Conference

The Chicago Ophthalmological Society has announced the preliminary program of the Annual Clinical Conference to be held May 19 and 20, at the Drake Hotel in Chicago.

The guest speakers will include Count H. Aruga, Barcelona, Spain; Mr. G. Leigh, London, England; Dr. Bernard Becker, St. Louis, Mo.; Dr. Harold G. Scheie, Philadelphia, Pa. and Dr. Robert N. Shaffer, San Francisco, Calif.

The subjects will include a symposium on surgery and medical therapy of narrow and open angle glaucoma; a symposium on secondary glaucoma; retinal detachment; corneal surgery and other subjects to be announced later.

Registration fee for the entire course including round table luncheons and dinner is \$45.00 and may be payable to the Registrar, Mrs. Mary E. Ryan, 1150 North Lorel Ave., Chicago 51.

The Seventeenth Annual Gifford Memorial Lecture will be delivered by Dr. Harold G. Scheie, Philadelphia, Pa. on Friday, May 19, at the Drake Hotel at 5:15 p.m. All physicians are invited to attend the Gifford Memorial Lecture and dinner which follows.

ISMA Members Invited to Attend Maternal, Infant Health Congress

Members of ISMA are invited to attend the Fifth Illinois Congress on Maternal and Infant Health, at the St. Nicholas Hotel, Springfield, Ill., on Feb. 8, 9 and 10. The program will include 30 breakfasts and eight luncheon conferences, round tables and formal papers with maximum participation in group discussion. Complete program, registration forms and additional information may be obtained by writing the Illinois Committee on Maternal and Infant Health, 116 S. Michigan Ave., Chicago 3.

WEST VIRGINIA MEETING PLANNED

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur

Springs, on April 6-8. Guest speakers on ophthalmology are Dr. Irving H. Leopold, Philadelphia and Dr. Harvey E. Thorpe, Pittsburgh.

The guest speakers on otorhinolaryngology will be Dr. John J. Shea, Jr., Memphis, Tenn., and Dr. Floyd J. Putney, Philadelphia.

In addition to the scientific program, arrangements have been made for a representative of Obrig Laboratories to discuss and show technics of contact lens fitting. Additional information may be obtained from the secretary, Dr. Worthy W. McKinney, 109 East Main Street, Beckley, W. Va.

Gill Congress is April 10-15

The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., will hold its 34th Annual Spring Congress in Ophthalmology and Otolaryngology and allied specialties, April 10-15. There will be 20 guest speakers and 50 lectures.

Continued

The Norbury Sanatorium

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Licensed — Jacksonville, Illinois**

FRANK GARM NORBURY, A.M., M.D., Medical Director

HENRY A. DOLLEAR, M.D., Superintendent

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Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

FUTURE MEETINGS

Continued

International Allergology Congress Scheduled for Fall in New York

Prominent physicians and scientists from all parts of the world have been invited to take part in the IVth International Congress of Allergology, at the Hotel Commodore, New York City, Oct. 15-20, 1961.

Among subjects to be presented are genetics in allergy, acquired tolerance, transplantation immunity, drug hypersensitivity, contact allergy, general mechanisms in allergy, mechanisms of antibody fixation, delayed hypersensitivity, auto immune processes, steroid therapy, new methods in allergy, etc.

All physicians registering are invited to present communications which will be grouped in various sections according to subject matter. An active program of entertainment is being arranged with several receptions, one at the Metropolitan Museum of Art, and a Banquet. For the ladies, there will be a program of luncheons, fashion shows and visits to the United Nations and other points of interest.

The registration fee for regular members will be \$45.00, for wives \$20.00. These registration fees will include the printed proceedings and admission to the receptions. The banquet will be charged separately. As the attendance is expected to be large, it is requested that persons interested obtain additional information from Dr. William B. Sherman, 60 East 58th St., New York 22.

Ob-Gyn College Plans Florida Session

Meeting at Miami Beach, Fla., April 21-28, will be the American College of Obstetricians and Gynecologists. Dr. Donald F. Richardson, 79 W. Monroe St., Chicago 3, has further information about this meeting.

Chose Washington for Meeting

The American Academy of Pediatrics will hold its spring meeting at the Sheraton-Park Hotel, Washington, D. C., April 10-12. The Executive Director, Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., may be contacted for further information. ◀



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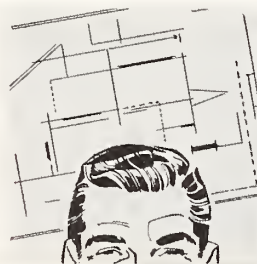
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REQUIRES
VISION**

Vision for planning man's future largely originates in the mind's eye — but it must be translated to the visual medium for understanding by those who follow the lead. White-Haines follows the professional man's lead in augmenting or correcting visual defects through fine quality ophthalmic craftsmanship, and has been a dependable source for more than half a century.

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34 Modern Laboratories

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KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

Wanted: Locations Physicians

General Practice

Eleuterio Carreire, 1330 Hyde Park, Chicago 15, Ill.
Arthur A. Haynes, 57 N. Somerville, Apt. 704,
Memphis, Tenn.
Jose L. Guevara, 1528 Olive Ave., Chicago 26, Ill., *as-
sociate in surgery.*
Cleto Elequin, Jr., 233 Collegeview Ave., Lexington,
Ky.

Specialists

Aldo C. Sirugo, 4221 N. Paulina, Chicago 13, Ill., *ear,
nose and throat.*
Morton D. Willcutts, Jr., 445 Troy Dr., Corpus Christi,
Texas, *internal medicine—group or associate.*
Charles Allen, V. A. Hospital, Fort Howard, Md., *in-
ternal medicine.*
Paul David Siegel, 5414 Diamond St., Philadelphia, Pa.,
internal medicine.
James E. Kelly, 18283 Muirland, Detroit 21, Mich.,
internal medicine.
Roman E. Hammes, 707 Fullerton Ave., Chicago, Ill.,
pediatrics.
Willis A. Warner, 412 Grandview Court, Iowa City,
Ia., *anesthesiology.*

Marvin E. Weiner, 14th Field Hospital, APO 252, New
York, N. Y., *radiology.*

Don S. Cameron, 431 E. 51st St., Savannah, Ga., *gen-
eral surgery.*

Locations

Cass County—GALVESTON—pop. 950. Located ap-
proximately 10 miles from Kokomo. One
physician in the community. Contact Mrs. R.
J. Taylor, Clerk-Treasurer, Town of Gal-
veston, for details.

Cass County—LOGANSPOUT—pop. 21,700. Opening
for an internist. Office space available. Two
hospitals. Primary sources of income industry,
railroads and farming. Contact Paul H. Wil-
son, M.D., 422 North St., Logansport, Ind.

Grant County—VAN BUREN—pop. 950 with popula-
tion in adjacent areas 2,500. One physician in
the community. Hospital facilities available at
Marion, Ind., 13 miles away. Contact Robert
Fincannon, President, Van Buren Chamber of
Commerce.

Tippecanoe—WEST POINT—pop. 350 with a sur-
rounding population up to 15,000. New medical
unit being constructed by the Lions Club with
225 families contributing funds. Contact
Charles R. DeVault, Box 163, West Point.

WABASH VALLEY HOSPITAL

"On the Banks of the Wabash"



A hospital for the treatment of Neuro Psychiatric Disorders
Open Psychiatric and consulting staff

DONALD R. KINZER, Business Manager

Lafayette, Ind. Phone Ri. 3-3841

Deaths . . .

Harry D. Brickley, M.D.

Dr. Harry D. Brickley, 74, Bluffton general practitioner, passed away Nov. 16 at his home. He had practiced in Bluffton since 1920.

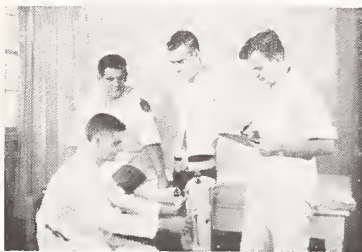
A 1913 graduate of the Chicago College of Medicine, Dr. Brickley was a World War I veteran. He was chairman of the board of education, having served as a Bluffton school trustee for 20 years, and was a past president of the Northeastern Indiana District Medical Association. He served as secretary of the Wells County Medical Society in 1921 and 1924.

Merle Davis, M.D.

A Terre Haute ear, eye, nose and throat specialist, Dr. Merle Davis, passed away Oct. 28 at his home. He was 42.

A graduate of the University of Tennessee Medical School in 1942, Dr. Davis served in the Navy as flight surgeon during and after World War II.

He was on the staffs of St. Anthony and Union hospitals in Terre Haute.



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training
for
HANGER
prosthetists**

Certified Prosthetists from the various HANGER offices have attended special courses on Upper and Lower-Extremity Prosthetics ensuring that HANGER Clients receive the best Prosthetic Service possible. The courses are approved by the American Board for Certification and given at the U. of California at Los Angeles, Northwestern U. and at New York U., in cooperation with the Prosthetic Research Board of the National Academy of Sciences. The use of the Adjustable Leg and the new "quadrilateral socket" were features of a recent series of intensive courses. The curriculum was centered around the Clinical Team (illustrated) usually composed of a physician, a prosthetist and a therapist and concerned with the integrated handling of each amputee case. Thus, doctors, interested in Prosthetics can be assured that HANGER Prosthetists are fully acquainted with the latest prosthetic methods.

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3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.

William H. Larrabee, M.D.

A 90-year-old New Palestine physician whose career included 62 years of medical practice and 12 years in Congress, passed away Nov. 16. He was Dr. William H. Larrabee, who up until the time of his death was still in medical practice and counseled patients.

Dr. Larrabee was a member of the Indiana House of Representatives from 1923-25. He won his first election to the federal House in 1931, and five elections thereafter.

Dr. Larrabee belonged to the New Palestine Christian church, Masonic Lodge, Lions Club, and Murat Shrine and Scottish Rite in Indianapolis.

Francis Hiatt Riley, M.D.

Dr. Francis H. Riley, retired Jamestown physician and a former Indianapolis doctor, passed away Nov. 7 in his home.

Dr. Riley had retired from active practice a few years ago.

For many years, he served on the board of directors of the Home for the Aged in Indianapolis; he was a past president of the Boone County Medical Society, and belonged to the Masonic Lodge and Nu Sigma Nu.

Walter E. Thornton, M.D.

Dr. Walter E. Thornton, Fort Wayne, widely recognized as an authority in the field of life insurance medicine, passed away Oct. 27 at the age of 82.

He was a board member and former second vice president and medical director of the Lincoln National Life Insurance Company, Fort Wayne.

Dr. Thornton, who retired as a Lincoln Life official in 1949, was a frequent speaker before insurance medical groups and had published several papers.

He was awarded his ISMA 50-year-club membership in 1951, having graduated from I. U. in 1901. Dr. Thornton entered insurance medicine after 12 years of private practice in Montpelier, where he also served three terms as Blackford County Coroner. ◀

The Journal of the
Indiana State Medical Association
MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1960-61 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of \$100.00, a second prize of \$75.00 and a third prize of \$50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1961.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

County Society News

Adams

Dr. R. S. Logan spoke on Acne, its Etiology and Management at the Oct. 11 meeting of the Adams County Medical Society. Twelve members attended.

The group held a general business session on Nov. 8 at the Decatur Community Center.

Allen

Dr. Leonard L. Lovshin, Cleveland, Ohio, spoke on the "Tired Mother Syndrome" at the Oct. 4 meeting of the Allen County Medical Society. There were 127 doctors and wives present.

Cass

Twenty-one members of the Cass County Medical Society met at Logansport Nov. 7 for a general business session.

Delaware-Blackford

At the Nov. 15 meeting of the Delaware-Blackford Medical Society at Muncie, 49 members were on hand to transact the society's business.

Floyd

Twenty-three members attended a business session of the Floyd County Medical Society Nov. 11 at New Albany. They heard reports on the ISMA annual meeting and discussed nominations for next year's officers.

Fayette-Franklin

Dr. Donald W. Brodie spoke on "Dangers of Alcoholism" at the Nov. 8 meeting of the Fayette-Franklin Medical Society, held at the Connersville Country Club.

Knox

Members of the Knox County Medical Society met Nov. 15 at Vincennes to discuss current legislative programs. Twenty-six members attended.

Lake

The Lake County Medical Society held their Nov. 16 meeting at the Norman Beatty Hospital, Westville, with Dr. David Morton, hospital superintendent, as the main speaker. There were 75 physicians present.

Lawrence

Seventeen Lawrence County Medical Society members met Nov. 2 for a noon business meeting, at the Dunn Hospital, Bedford.

Marion

Three Indianapolis physicians participated in the annual Conference of Physicians and Coaches, sponsored by the Marion County Medical Society and IHSA Oct. 27 in Indianapolis.

Conducting the sessions were Drs. Gordon W. Batman, Myron H. Nourse and J. Theodore Luros.

Marshall

Twelve members of the Marshall County Medical Society met Nov. 2 for a general business session and discussion of current legislative problems.

Montgomery

Dr. William Howard spoke on "Cause and Treatment of Eclampsia" at the Nov. 17 meeting of the Montgomery County Medical Society. Twenty-six doctors attended.

Orange

Dr. Robert Lych spoke on his original work in detection and treatment of congenital bladder obstructions at the Nov. 1 meeting of the Orange County Medical Society. Seven members were present.

Porter

Members of the Porter County Medical Society have announced that they will support the local chapter of the American Cancer Society in a program to encourage pap smears and biopsies for cancer detection.



"I'm sorry, Madam, I didn't mean to frighten you—I'm just on my way to take my fencing lesson."

Putnam

Dr. John Scott spoke on "Heart Murmurs in Children" at the Nov. 11 meeting of the Putnam County Medical Society. Fourteen doctors attended.

Vanderburgh

More than 60 coaches from Evansville and adjoining counties attended the annual Vanderburgh County Medical Society coaches' athletic injuries conference, Dec. 5. Under the chairmanship of Dr. Wallace Ayde, the program included talks by Dr. John Sterne and a local dentist.

At the groups Nov. 15 meeting, the program was on professional liability, using recordings of an ISMA convention speech, followed by comments from the society's legal counsel.

Wayne-Union

Dr. Morris Snyder is the new president of the Wayne-Union Medical Society; assisting him during the next year will be Drs. James Z. Logan, president elect; Thomas Shields, secretary; James Dagge, treasurer, and William Barton, censor.



"Didn't you say your wife was the bearded lady in a circus?"

Every man naturally persuades himself that he can keep his resolutions, nor is he convinced of his imbecility but by length of time and frequency of experiment.

—Samuel Johnson.

...MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?
OUTMODED AS GODEY'S FASHIONS!

R^x NEW
PRENALIN-O[®]
PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides:

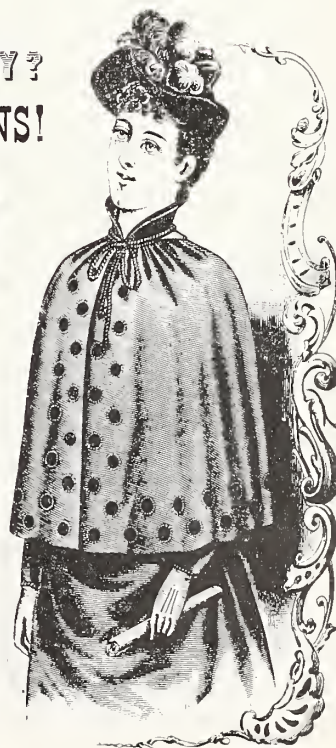
Ferrous Fumarate (Iron)	150 mg.
Deep sea oyster shell (Calcium)	600 mg.
Vitamin C	50 mg.
Vitamin A	4000 USP Units
Vitamin D	400 USP Units
Vitamin B-1	2 mg.
Vitamin B-2	2 mg.
Vitamin B-6	0.8 mg.

Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Folic Acid	0.25 mg.
Niacinamide	10 mg.
Vitamin K (Menadiolone)	0.25 mg.
Rutin	10 mg.
Sodium Molybdate	3 mg.
Fluorine (Calcium Fluoride)	0.25 mg.
Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG

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Put your
low-back patient
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*Soma relieves stiffness
—stops pain, too*

The muscle relaxant with an independent pain-relieving action

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(carisoprodol, Wallace)

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YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity—and fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE:** 1 TABLET Q.I.D.

Association News

EXECUTIVE COMMITTEE

Nov. 1, 1960

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Ralph Hamill, attorney; James A. Waggener, executive secretary.

Membership Report

Number of members as of Oct. 31, 1959..... 4,237
1960 members as of Oct. 31, 1960:

Full dues paying	3,616
Interns	33
Residents	173
Council remitted	44
Senior	389
Military	35
Honorary	1

Total 1960 members as of Oct. 31, 1960..... 4,291
Gain over last year

54
Number of members Dec. 31, 1959..... 4,256

Number of AMA members as of Oct. 31, 1959_ 4,108

1960 AMA members: Dues paying..... 3,474

Exempt, but active

677

Total 1960 AMA members as of Oct. 31,

1960

4,151
Gain over last year

43
Number of AMA members as of Dec. 31, 1959_ 4,210

Number who have paid state dues but not AMA
dues in 1960

125

Headquarters Office

Budget. The secretary reported that the auditors had not yet completed the annual audit and the budget would not be ready for consideration until the next meeting of the committee.

Tax exemption. The secretary read a letter from the Marion County Board of Review in which the Association was granted exemption from payment of personal property taxes.

Statement of Receipts and Expenditures and budget balances and the treasurer's report as of Oct. 31, 1960, were reviewed and approved by consent.

Legislation. The chairman of the Commission on Legislation reported on some of the forthcoming issues and read a letter from the Hospital Association concerning changing the law having to do with the authority of the County Council to control the budget and the expenditure of county hospital funds. This letter was referred to the attorney for study.

Annual Convention, Indianapolis, Oct. 24, 25 and 26, 1961

Annual banquet—president's night. Minutes of the meeting of Oct. 5, 1960, of the Commission on Convention Arrangements were read. By consent the Commission is to be instructed that only Wednesday night, Oct. 25, shall be a planned evening. This will be the annual dinner and president's night, with entertainment, and no speaker other than the president, and will be held at the Indiana Roof.

Bowling tournament. Letter from Dr. Glen Ryan requesting authority to establish a bowling tournament as a part of the annual convention was read, and this was approved by consent.

Future Convention Dates, as follows, were approved by consent:

1961—Oct. 24, 25, 26, Murat Temple, Indianapolis.

1962—Oct. 7, 8, 9 and 10, Sheraton Hotel, French Lick.

1963—Oct. 15, 16 and 17, Murat Temple, Indianapolis.

1964—Oct. 11, 12, 13 and 14, Sheraton Hotel, French Lick.

Organization Matters

Science Fairs. The secretary read a letter from Dean Kaufman of Butler University concerning the Ninth Indiana Regional and the National Science Fairs for 1961 and also the letter which he had written to Dr. Kaufman. By consent the secretary's reply was approved and he was instructed to further notify Dean Kaufman that the State Medical Association would not participate in the 1961 Fair.

Medical Student Recruitment. Dr. Owsley read a communication concerning medical student recruitment and by consent it was agreed that the appropriate Commission should undertake this activity.

Dr. Owsley also discussed the advisability of having the Council formally adopt a motion requesting the Blue Shield Plan to forward to the Grievance Committee of the Indiana State Medical Association for its review and action claims which would constitute an abuse. By consent it was agreed that this should be placed on the agenda for the next Council meeting.

Dr. Wood discussed the formation of a group in Indiana to provide loans for college students and explained that this would give the Indiana State Medical Association an opportunity to expand its \$40,000.00 investment into a total of \$480,000.00 worth of loans. This matter is to be studied further and referred also to the Commission on Medical Education and Licensure for study, upon motion of Drs. Owsley and Glock.

The exchange of correspondence between the headquarters office and the Vanderburgh County Medical Society concerning a Chicago physician who is advertising a Plastic Surgery Center in the Evansville telephone directory was read. The secretary reported on the conference he had had with the officials of the Indiana Bell Telephone Company concerning this situation and upon motion of Dr. Owsley, by consent

this information is to be referred to the Better Business Bureau and to the American Medical Association.

The request of the Indiana Academy to use the mailing list of the State Medical Association for announcing its annual scientific session was approved by consent.

A letter from Mrs. Helen Johnson, Associate Director, Nursing Services, Indiana University Medical Center, requesting the Association to name representatives to the Department of Nursing Service, Indiana University, for consultation in planning some short courses in nursing was read. By consent the following members were named as a committee to represent the Association for this purpose:

Glenn W. Irwin, Jr., M.D., Indianapolis, chairman.

Nathaniel D. Ewing, M.D., Vincennes.

Glynn A. Rivers, M.D., Muncie.

Harry E. Klepinger, M.D., Lafayette.

A letter from the Medical Society of Virginia enclosing a resolution adopted by that society and the resolution were read to the committee and upon motion of Drs. Owsley and Glock the secretary was instructed to transmit a copy of this resolution to the delegates to the AMA with instructions that they are to support this resolution.

The secretary reported on the latest ruling of the Joint Commission concerning osteopaths and read a letter from the AMA regarding their position.

New Business

A letter from Dr. Joseph G. S. Weber, Terre Haute, concerning a letter he had received from the State Board of Accounts concerning relationships between radiologists and hospitals was referred to the legal counselor for discussion with the State Board of Accounts.

A letter was read concerning the Government in Action Project education program which is being established under the sponsorship of the League of Women Voters. The secretary was requested to attend a meeting of the Indianapolis Project Committee on Nov. 3, or have a representative of the Association attend.

President Owsley read a letter which had been written by the secretary to the Welfare Director, and upon motion of Dr. Owsley, by consent the secretary was

instructed to supply each member of the Executive Committee and the commission on Governmental Medical Services and the Council with copies of this letter.

Medicare

Two changes in the Medicare contract were referred to the Committee. By consent the president was authorized to sign, following approval of the changes by the legal counsel.

The Journal

A Release of Copyright Document received from Arnold Lieberman, M.D., New York, in which he requested *The Journal* to release its copyright on all articles which have appeared in *The Journal* over his name, or will appear in the future; to him, was discussed. The attorneys questioned the execution of this document, and upon motion of Drs. Covalt and Stimson this was referred to the Association counsel for study and recommendation.

Medical Defense

A letter from the Physicians & Surgeons Underwriters Corporation, Minneapolis, addressed to President Mericle, was read, and this correspondence was referred to the Commission on Medical Economics and Insurance.

Future Meetings

Annual Chamber of Commerce dinner, Thursday noon, Dec. 1, 1960. Upon motion of Drs. Glock and Covalt the chairman of the Commission on Legislation was authorized to purchase 20 tickets for this meeting.

Seventh Annual Conference on Mental Health, Chicago, Jan. 20 and 21, 1961. On motion of Drs. Stimson and Glock the appropriate commission was authorized to send one representative to this meeting.

Attention was called to the Second National Conference on Medical Aspects of Sports, to be held in conjunction with the Washington meeting of the American Medical Association, on Nov. 27, 1960.

There being no further business the Committee adjourned to meet again in Indianapolis on Wednesday, Dec. 7, 1960, the chairman to set the time of the meeting. ◀

Annual Heart Issue

Each February the Journal devotes its cover and scientific section to various aspects and problems of heart disease. We are pleased to announce that this year, owing to a tremendous and gratifying response to our call for such original work, the Heart Issue will be continued in the March Journal.

—The Editors

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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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**References available on request.*



This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.--Spokesmen for the medical profession at the White House Conference on Aging supported the Kerr-Mills voluntary program for health care of elderly persons as an efficient, economical way to furnish assistance to those who need help.

Leading physician delegates to the conference also continued vigorous opposition to the Social Security approach espoused by organized labor.

Continuing their all-out campaign for the Social Security approach, labor union leaders used the conference as a forum for further attacks on the medical profession.

SOCIAL SECURITY APPROACH WOULD BE 'TRAGEDY'

Dr. J. Lafe Ludwig of Los Angeles, chairman of the American Medical Association Council on Medical Service, told a pre-conference meeting of the physician delegates that it would be a "national tragedy--unfair to old and young alike--if the Kerr-Mills law should be shelved for a Social Security plan for medical care of the aged.

"Federal medicine would mean red tape, bureaucratic control and high costs," Dr. Ludwig said. "Most important of all, it would mean inferior medical care for the people whom we are trying to help."

Describing the Kerr-Mills law as an "historic milestone," Dr. Ludwig said the "overwhelming majority" of the nation's physicians believe it is "an excellent law which can and will work and deserves every opportunity to do so."

URGES PROMOTION OF GOOD HEALTH

Dr. Leonard W. Larson of Bismarck, N.D., president-elect of the AMA, told the conference's Health and Medical Care section that more attention must be given to keeping older persons healthy. He was chairman of the section.

"We spend millions of dollars and hours developing sound, well-based programs for care of the sick, but at the same time we virtually ignore the vast opportunities for preservation and promotion of health," Dr. Larson said.

"We must do more than react to the minority of older persons who are ill--we must act for the great majority who are well."

In a statement issued in Chicago, Dr. E. Vincent Askey of Los Angeles, president of AMA, branded as false an allegation that the White House

Continued

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MONTH IN WASHINGTON

Continued

Conference had been "captured" by organized medicine, private insurance and business interests. Dr. Askey specifically referred to such a charge made by Prof. Wilbur J. Cohen of the University of Michigan, but the AMA president's statement applied to similar charges made by representatives of organized labor.

Dr. Askey implied that, "if anyone has a legitimate complaint regarding the choice of personnel directing the activities" of the key section on income maintenance, it was opponents of the Social Security approach.

MEANY ACCUSED OF 'ATTEMPT TO UNDERMINE'

Dr. Ludwig also answered organized labor's attacks on the AMA at the conference. Dr. Ludwig accused George Meany, president of the AFL-CIO, of "attempting to undermine" the conference to "further his own partisan interests."

"Meany obviously is prepared to go to any extreme to impugn the motives of those who disagree with him," Dr. Ludwig said. "Delegates to this conference representing medicine and many other groups came here in a spirit of cooperation determined to take realistic action to help the elder citizens of this country."

"Meany, through his campaign of smear and hostility, is making this difficult if not impossible."

Dr. Ludwig said that some labor leaders "obviously are more interested in saddling the people of this country with a system of socialized medicine" than he is in "helping those older people who really need help."

"Meany and such of his cohorts as Sen. Pat McNamara (D., Mich.) appear to be doing their utmost to create so much confusion that recommendations of the State Conference on Aging will be forgotten," Dr. Ludwig said.

"Of the 30 states making specific recommendations regarding financing of medical care for the aged, only 10 favored the Social Security tax."

President Eisenhower urged the 2,700 delegates to the conference to reconcile their differing views and agree on a sound program. He told the delegates it was their responsibility to provide "some kind of guidance for Congress to use in its future deliberations."

President John F. Kennedy declined an invitation to address the Conference as President-elect. He and Congressional Democratic leaders decided weeks before the Conference to make medical care for the aged under Social Security an Administration priority bill for early submission to Congress.

SOME KEY DEMOCRATS WON'T FOLLOW KENNEDY

But some key Democrats in Congress announced they would not go along with President Kennedy on the issue. Sen. Robert S. Kerr (D., Okla.), co-author of the medical-care-for-the-aged program approved by Congress last year, said it should be financed by a general tax--"not a limited tax like Social Security."

Continued

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MONTH IN WASHINGTON

Continued

Similar opposition to the Social Security approach was expressed by Sen. John J. Sparkman (D., Ala.). Chairman Harry F. Byrd (D., Va.) of the Senate Finance Committee earlier had said he was convinced that providing medical care for the aged under Social Security would lead to socialized medicine and possibly bankrupt the Social Security trust funds.

Despite the Kennedy Administration's espousal of the Social Security plan, the AMA pledged its continued cooperation to the Department of Health, Education and Welfare on other health programs.

A group of AMA officials headed by Dr. Askey told the new H.E.W. secretary, former Gov. Abraham Ribicoff of Connecticut, at a pre-inaugural conference, that the Association "pledges its continued cooperation to H.E.W. to work for the best medical care for the nation." The AMA "has always had a deep sense of responsibility for the health needs of the people," Dr. Askey said.

The AMA officials also advised Ribicoff that they would help implement the Kerr-Mills law in any way possible. ◀

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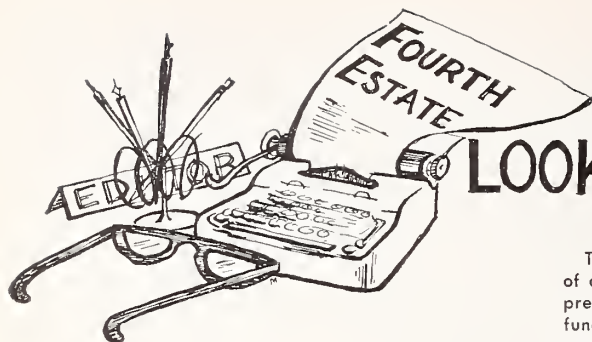
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¹ Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.



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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Medical Bill—What Is It?

Indiana's welfare officials have admitted that they are plainly baffled by the new federal law which supposedly provides medical care for older citizens. The Hoosier welfare department is now in a state of suspicious shock. The one certain answer a reporter can get is, "We don't know, and we're not going to say."

This condition is not confined to Indiana. In Alabama, the commissioner of pensions and security has taken a long look at the new federal statute. His considered opinion is that there "just ain't no such animal."

What has the Alabama officials puzzled is the fact that their state offers no medical care to people receiving old age assistance. Yet, the federal bureaucrats estimate that Alabama is spending about \$2 a month each for nursing home care for some 100,000 persons on old age pensions. The flaw in this estimate is that Alabama doesn't have any records on nursing care, and whatever information might exist is kept by the counties.

In that state, then, there is the ridiculous situation in which federal functionaries are trying to give away \$4,000,000 to officials who are afraid to take the money. This is true in spite of the guess that Alabama will have to spend only \$9,000 in state funds to get back \$4,189,000—if the program is really what the federal bureaucrats claim it to be.

Indiana should maintain its existing program of comprehensive medical care for the older Hoosier citizens receiving old age assistance. This has been done successfully for 13 years.

In the meantime, Indiana congressmen should prepare now for drastic surgery on a law which was described by the Montgomery (Ala.) Adver-

tiser as "an election-year bauble." The statute was passed as a piece of "must" legislation. The description is accurate. The law *must be rewritten or wiped out!*

Indianapolis Star
Sept. 24, 1960

A Question of Sanity

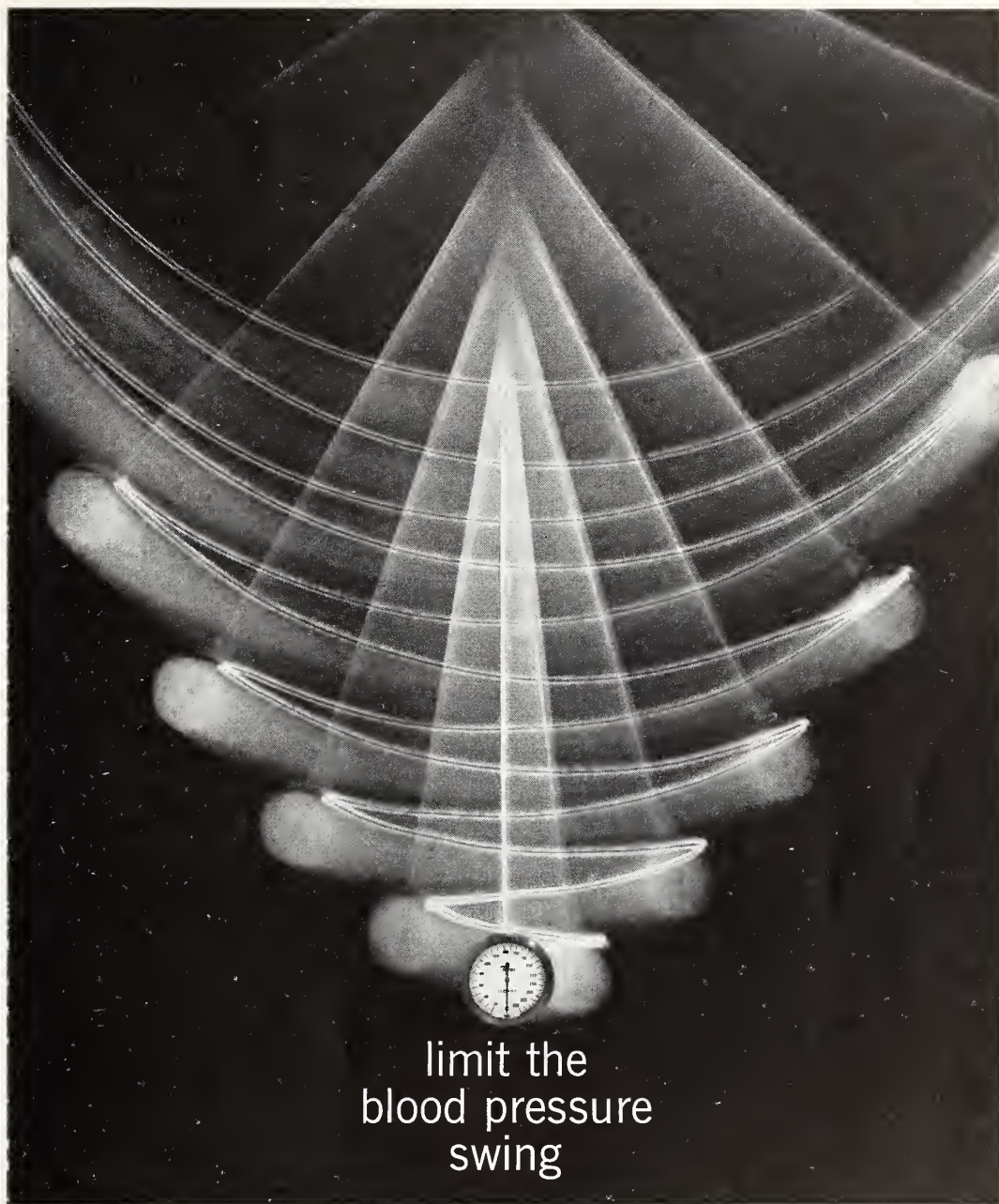
There seems a strong likelihood that the matter of mental health facilities and treatment will be a prominent concern in the 1961 session of the General Assembly and in the administration of Governor-elect Matthew Welsh.

This concern may be expected to begin with the question whether physical facilities are adequate. We hope and trust that very quickly and positively it will shift to the question of whether staffing and procedures are directed, as effectively as they might be, toward the goal of getting patients *out* of the institutions as soon as possible. This is much more important than size and number of buildings in determining whether facilities are adequate.

There is still another matter which ought to get very searching examination as part of the current concern for mental health matters. This is the procedure by which patients get *into* mental institutions—both public and private.

Marion County courts have been struggling for about two years with the question of whether a young man is mentally competent to stand trial on an accusation of beating to death an elderly woman. The heart of the question is whether he is mentally capable of assisting in his own defense. If he is not, then under the law it would be a violation of his rights to try him and send him to prison on a criminal charge.

Continued



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FOURTH ESTATE

Continued

But this same man, also under the law, could be kept prisoner for the rest of his life in a mental institution without ever himself appearing in court or having the opportunity to participate in his own defense, whether he's able to or not.

And the same is true for some other man or woman accused of nothing worse than saying things or doing things which suggest to others that he might not be "all there." On such an accusation a person might be sent off to a mental institution without ever having a chance to offer his own defense in court, or anywhere else except before a couple of court-appointed psychiatrists and the staff of the institution to which he is sent. If he has no one on the outside to intervene, and if those whom he is able to reach are of the opinion that institutional confinement is best for him, he may never again see or hear from the outside world.

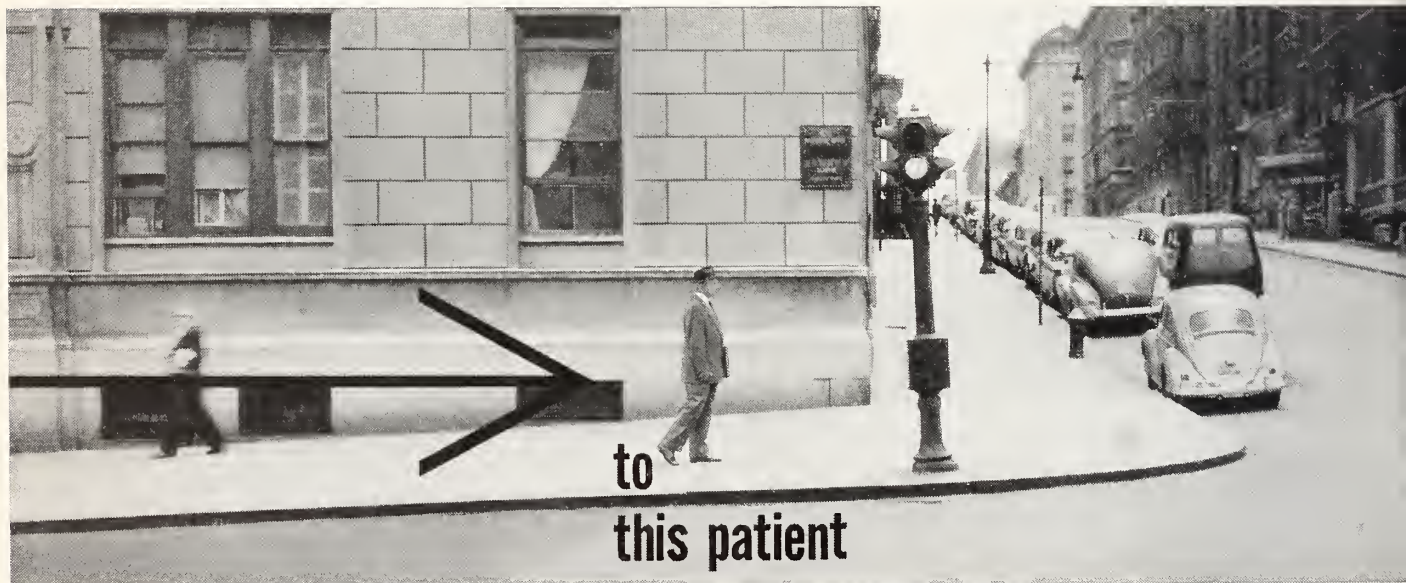
This not only "might" happen. It does happen. The trouble with the commitment procedures

is that once the commitment process moves to the point that the "patient" is taken into custody—the point corresponding to arrest in the case of a person suspected of crime—the person accused of insanity has no legal protections at all within his own reach. If he does not have somewhere outside these processes a friend to initiate a defense on his behalf, he is helpless in the hands of those who seek to commit him.

That is comparable to arresting a suspected criminal and thereafter allowing him to see or communicate with no one except the prosecutor and the jailers. American society would never tolerate that. But society seems oblivious to the parallel plight of the suspected mental patient.

This is a phase of the mental health problem which should be opened wide and thoroughly examined, along with other phases. Surely it is possible to provide orderly and humane commitment procedures, for those who need them, without the existing possibilities of callous abuse of individuals who need most of all a chance for self-defense.

Indianapolis Star
Dec. 17, 1960



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The Editor's Corner

Good Evening.

Across the street from our home lives a Delaware County physician, Dr. Stewart Brown.

His offices are in Albany. He's a general practitioner. If the ethics committee of the Delaware-Blackford Medical Society takes offense at this, let it take offense at us, not at our doctor-neighbor. For he has had nothing to do with what we are about to write. We take full responsibility. He would seriously object to the use of his name, just as have so many of our doctor friends, Will Moore, Tom Owens, Bob Butterfield, Howard Hill, to name only a few, so seriously objected when we have used their names in the past. But doctors are not sacred cows, to us.

Our neighbor is greatly worried about socialized medicine. He believes it is a definite threat to the future of medicine. Not as to his own future. He believes he probably would make more money from socialized medicine than he is now making. But, as he told us, he would not want to practice medicine under a socialized pattern.

He's very sincere about this.

As to ourselves, we feel the same.

We want always to be in the position of calling a doctor of our own choice when there is sickness in our family. We want always to be in the position of depending on the advice of the doctor, of our own choice, about what should or should not be done.

We do not want any governmental bureaucrats to tell us what we **MUST DO** when there is serious illness in our family. We would **NOT WANT** a doctor assigned to us by a governmental bureaucrat. We do not trust bureaucrats in any way.

We have had our full share of disagreements with Muncie and Delaware County physicians. We have disagreed with these men of medicine many times. The very fact that they hold a Doctor of Medicine degree does not impress us to a great degree. We believe they are wrong, at times. We admit, also, we are wrong so very much of the time. But we want to be in the position of talking to these physicians, as man to man. Not as a governmental bureaucrat would

Continued



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FOURTH ESTATE

Continued

be talking to us. "Take it or leave it," he would most surely say. And, we do not like that kind of talk.

We believe in this presidential campaign year, there are many things that should be seriously considered by the man or woman, as he or she goes to the polls. Socialized medicine is one of those very important matters.

Now, we are going to make most of our doctor friends a little angered with us.

What, gentlemen, may we ask, are you doing about it?

What are you doing, you practitioners of medicine and surgery, to combat the all-out move that is taking this country closer, day by day, to socialized medicine?

Our answer. So very damned little.

Muncie Press
Oct. 18, 1960

An Awful Mess!

Three days of confusion have brought only a little more confusion to the manner in which Indiana will be affected by the new federal law on medical care for the aged.

State officials first had visions of the kind of scheme that politicians ask for in letters to Santa Claus. For a brief two days, the Statehouse was certain Santa Claus was going to bring Indiana a multi-million dollar program of care for aged persons who are "medically indigent." It was a cheerful plan to use federal money as state funds to match other federal money to get even more federal funds.

A Social Security officer in Washington knocked a big hole in Santa's bag of goodies for Indiana. There is a suspicion that Charles Hawkins, the Washington bureaucrat, may even go down in Hoosier history as having shot Santa himself.

At any rate, through the welter and fog of general confusion, this much now is clear.

Indiana since 1947 has had a comprehensive medical care program for citizens receiving old age assistance. Congress strained and struggled in the shirt-tail session to do what Indiana accomplished 13 long years ago.

Under the new federal law which finally caught up with Indiana, this state will receive something like \$500,000 a year in additional fed-

eral funds for the existing old age plan. Hoosiers, of course, will have to pay every penny of that half-million dollars in federal taxes, and more besides. This isn't "free" money.

The new federal law is so confusing that the confusion reigns from Indiana all the way to Washington. Indiana's public welfare officers got a meaning from the law different from that accepted in Washington, while a regional welfare man in Chicago didn't agree with either Indianapolis or Washington.

The new federal law clearly contradicts other statutes.

The new law makes the records of the "medically indigent" secret, but leaves open the medical records of those now receiving old age assistance. The new law won't let any state set a residency requirement, but all states have some rules on residence for those now receiving old age assistance. The new law would permit an entirely different set of rules to apply to the "medically indigent" as opposed to those receiving old age assistance.

In short, the new law is a miserably botched piece of legislation which was rammed through Democratically-controlled Congress. It is inconsistent to the point of incoherence, a fact which is now obvious.

There is only one good approach to this kind of mess.

The Indiana General Assembly should direct the public welfare department to reduce the state and county shares of the existing old age assistance plan by whatever amount of federal money may come in. At present, this would mean a reduction of more than \$500,000 a year. This would permit some small tax relief to Hoosiers.

Such a move would also avoid setting up medical care programs which likely would be conflicting, expensive and burdensome. This kind of action would also protect the public's right to know how its welfare funds are spent.

Then, the General Assembly should hope that the next Congress will wipe out this federal law which is a horrendous assortment of bad ideas.

In that way, Indiana could keep right on taking care of the elderly people in the state as it has done ever since 1947. If other states would shoulder the same responsibility, there would be no need for federal law, anyhow.

Indianapolis Star,
Sept. 18, 1960

Continued



in infectious disease^{17,22,30,36}

in arthritis^{18,19,20,29}

in hepatic disease^{2,3,4,5,36}

in malabsorption syndrome^{1,2,6,27}

in degenerative disease^{6,7,19,20,40}

in cardiac disease^{23,28,29,38,41}

in dermatitis^{24,39}

in peptic ulcer^{8,21,38}

in neuroses & psychiatric disorders^{25,26}

in diabetes mellitus^{11,32,33,38}

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1-41 a list of the above references will be supplied on request.

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FOURTH ESTATE

Continued

From Other Editors:

Nobel Prize in Medicine

One of the most fascinating as well as the most frustrating objectives of modern surgery has been the problem of transplantation of tissue from one individual to another. The reason, it has been found, is the "uniqueness of the individual," each possessing a unique immunological pattern. When a tissue, or an organ, from one individual is transplanted to another, the body immediately identifies it as a foreign substance and mobilizes its immunity mechanism in such a way as to create antibodies that soon destroy the foreign invader.

It is this uniqueness of the immunological pattern that has stood in the way in what would otherwise be one of the greatest medical triumphs, the ability to transplant whole vital organs into bodies whose very lives depend on the practicability of such a procedure, including even the replacement of damaged hearts.

For their epoch-making animal experiments, in which they demonstrated that the "immunity barrier" can be broken, by making it possible to give the animals an "acquired immunological tolerance," Sir Macfarlane Burnet of Melbourne and Dr. Peter Brian Medawar of London have received the 1960 Nobel Prize in Medicine and Physiology. The discovery, it was pointed out, represents "a major breakthrough" in the field of immunology and has opened a new chapter in experimental biology, with several problems of great practical medical importance opened to attack. As a result of the "breakthrough," the citation in the award states, "new aspects are emerging on the causes and treatment of the large group of disorders in which normal immunity reactions represent an obstacle rather than a help, or where abnormal reactions are at the root of the trouble." Questions to which answers are emerging as a result of the discoveries by Sir Macfarlane and Dr. Medawar are those of the treatment of certain radiation injuries, leukemia and certain allergic disorders.

The scientific world, and mankind at large, will hail the award with universal congratulations and gratitude not because the discoveries have immediate practical applications, as much more study and experiment will be required before it becomes possible to give ailing human beings

new organs for old, but because the door has at least been opened and there can be no question that a new era in the transplantation of tissues and organs is on the way.

Kokomo Tribune

Nov. 1, 1960

(Reprinted from
New York Times)

Speaking of Delinquency

Like some other self-styled liberals, Senator Javits thinks the new Congress will be "delinquent" unless it enacts a big program to deal with juvenile delinquency.

More specifically, he wants his fellow lawmakers to adopt his own program. It calls for five years of federal fund-furnishing to assist states and municipalities in operating large juvenile delinquency control programs, in doing research and developing new methods of dealing with "behavioral problems," and in training staffs. There would be a federal advisory council consisting of public officials and community leaders.

Now if there is any problem in this country which is purely local in nature, it is the problem of juvenile delinquency. It is a problem of the neighborhood, the school, the home. A community like New York City has no lack of officials and citizens and—most importantly—police power to deal with it. If that community has failed, it is sentimental nonsense to say it will be saved by the federal government. Washington can only work through these same community officials, citizens, police and courts.

There may be something touching in this faith in the federal government, this naive belief that the answer to any and every kind of problem is to throw it at Washington. But whatever else may be said of that attitude, it must be judged delinquent in common sense.

Wall Street Journal

Nov. 21, 1960

Not Enough Doctors

LaPorte Herald-Argus: Does the United States have enough doctors? Are there enough students entering medical schools these days to fill future needs?

The Association of American Medical Colleges claims that declining medical school applications and rising costs to both students and institutions have led "to a crisis stage."

Continued

IN CONTRACEPTION...



PHOTOGRAPH: HUMAN SPERMATOZOA. 400X. HEMOCYTOMETER DIFFUSION TEST.

WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel 7-chloro-4-indanol, a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution

of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



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Supplied: Lanesta Exquiser® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

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FOURTH ESTATE

Continued

The association further contends that increasing costs of a medical education constitute a formidable barrier to lower income and lower middle income groups.

Indiana with only one medical school is in the lower bracket of states in the number of doctors per 100,000 people. The Indiana ratio is below 100 for each 100,000, whereas the national average is 118.

Without any doubt, the major answer is the creation of many millions of dollars worth of scholarships for qualified students with medical aspirations. Unless this is done, the shortage in the decade ahead will become more than merely serious.

Indianapolis Star
Dec. 7, 1960

Will We Learn

South Bend Tribune: Let a plane crash, killing a score or more persons, and the public reaction is one of horror.

No comparable reaction follows a particularly bloody weekend on the streets and highways of America or in any given area of the United States.

This is unfortunate for two reasons. There is little that people can do individually to avert air tragedies. There is a great deal that they can do individually, however, to promote safety on the highways.

The deaths of 46 persons on a recent weekend in Indiana and Michigan—13 in Indiana and 33 in Michigan—was one of those particularly horrible and frightening experiences that should bring drivers to their senses.

The prospect, however, is that it won't have that effect.

The most persistently baffling problem for safety specialists and the American public is how to awaken in the individual the awareness of his personal responsibility for his own and others' safety every time he takes the wheel.

Speeding, driving after drinking and violations of the rules of the road are potentially deadly. Even the reckless drivers will not argue the point.

The only surprise is that so many who recognize the uneven odds are willing to gamble when the stake may be life itself.

Indianapolis Star
Nov. 16, 1960

The Semi-Annual Clean Sweep

Six month ago, the streets of Indianapolis were "swept clean" of narcotic addicts and peddlers in the biggest effort ever made by police to reduce this particular type of crime. This week, Federal agents had to move back into Indianapolis to arrest three men said to be the "top" narcotic hustlers in town.

Six months ago, the clean sweep was a joint operation of Federal and city officers. The same system was used again this time. In fact, the same two officers, Sergeants William E. Owen and Robert E. Keithley, were in on the apprehension of the current alleged leaders of narcotics racketeering in the city.

Using experienced police in this sort of work may sound like a sound idea. Actually, it's the hardest possible way to enforce narcotic laws, since the officers and the narcotics sellers soon come to know each other, by sight and by mode of activity. Instead of rotating local police on the narcotics detail, the same men are doing the same job today they were doing six months ago, and for years before that.

The use of narcotics in itself is a personal tragedy, but the public becomes involved when the addict turns to crime to finance his habitual need for drugs. For that reason, Indianapolis ought to provide protection for the majority of people who may be endangered by this traffic, and its criminal side-effects.

Surely there must be some way to use more than just two officers on the city's narcotics detail. Putting capable, intelligent police in this work on a rotating basis should result in greater pressure on the professional drug peddlers and their clients.

Otherwise, the city's "clean sweep" of narcotics offenders might come to attain the status of a semi-annual clearance sale. Indianapolis deserves better protection than that.

Indianapolis Star
Nov. 16, 1960

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 54 — February 1961 — Number 2

Patients with impaired cardiac function are happier and their hearts do better if they are able to perform gainful work and stay within their cardiac output budget. Determination of cardiac work budget constitutes an important medical decision.

Problems in Functional Evaluation of Cardiacs

ROBERT B. CHEVALIER, M.D.*
Indianapolis

ABILITY OF THE CARDIAC to work is an ever-present problem besetting most practicing physicians. With advances of medicine giving the average person a longer time to succumb to cardiac disease, it will continue to represent a major source of concern. This paper does not attempt to answer this matter; it is an effort to summarize some of the current feelings in this field.

The problem is of no concern to the individual who is totally incapacitated by his cardiac experience or who suffers only temporarily from some transient cardiac disease. It does deal with that large number of individuals who have or have had angina, myocardial infarctions, rheumatic valvular disease and all of the other cardiac insults that are capable of influencing to a

greater or lesser degree an individual's life patterns.

Everyone acknowledges the need for functional evaluation of cardiacs. Unfortunately, there is no simple method that will serve as the panacea of the many problems in such an evaluation. The entire field of such study is in its relative infancy and will, without doubt, reach an early maturity aided by many of the modern devices for mensuration and recording. One has only to know a little about the normal physiology of work in order to see the additional complexities superimposed by a diseased heart.

Normal Physiology of Work

It lies far beyond the scope of this paper to give more than a brief resumé of the normal physiologic response to work and exercise. This discussion will be limited, in the most part, to a consideration of cardiopulmonary responses to work. There is an increase in the many parameters that one can measure, in response to increases in work load. The degree to which they increase is in a great measure predicated on the

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type of work and the strenuousness of the task. Most of the assumptions made here will be based on work done with the heavy muscle groups in the legs. It has been demonstrated that work involving only the arms produces different results to the various physiologic measurements.¹

According to Mitchell et al.² if one works to a ninefold increase in oxygen uptake, which would be a high level of work in terms of calories or kilogrammeters, several changes occur. Cardiac output increased 4.3 times the resting state; there was an increase of two times in the pulse, stroke volume and central blood volume. In addition, it was found there was widening of the arteriovenous oxygen difference. Physiologically speaking, other changes occur in the course of normal work. Blood pressure, particularly the systolic phase, rises in response to increasing work loads.³ Rise in diastolic pressure is usually minimal and may actually show a decrease in response to increased work loads.

It has been previously mentioned that oxygen intake rises in response to work and this fact has been utilized by several authors in the development of a means of evaluating response to aerobic work.^{1,2,4} Pulmonary ventilation increases with an increase in work load. This is a function of increased respiratory rate as well as increased tidal volume. During peak performances one of the criteria used by Balke et al.⁵ was the rapid rise in respiratory rate. The respiratory exchange ratio or respiratory quotient is another of the pulmonary parameters that has great relevance in work physiology. As long as the individual is doing basically aerobic work the amount of carbon dioxide blown off will not exceed the amount of oxygen taken in and the respiratory quotient will be less than 1.0. When the individual reaches a high level of work and aerobic work capacity begins to regress, then the respiratory quotient will exceed 1.0.

More should be said about the response of pulse rate to exercise. This is especially adaptable to measurement and actually serves as a most useful index of cardiac response to work. Almost all investigators agree that there is a linear relationship between the pulse rate and work load. Many people have shown that the range of maximum response of the pulse rate to excessive work loads is about 180-190 beats per minute. This figure is especially true for healthy young adult males. When the heart reaches these rates

then the other parameters studied indicate that the body is beginning to decompensate from a physiologic point of view. This represents the level of peak aerobic efficiency. Suffice it to say, that anaerobic work can only be done for a short time. Bursts of work at a high level of energy are done anaerobically, but this cannot be sustained. It is unlikely that the symptomatic cardiac should ever willingly do much anaerobic work.

The previous effects have been readily measured, but evaluation of what happens within the heart is an altogether different matter. A stumbling block was overcome to a great extent when Sarnoff et al.⁶ developed an experiment with the dog that enabled studies to be carried out on the non-failing supported heart. This will no doubt enable investigators to study actual changes within the dog heart under more physiologic circumstances. It has been shown by analysis of coronary sinus blood that the heart muscle is very efficient in extracting oxygen. Horvath⁷ stated that the coronary arterio-venous difference was 12 vols. percent as opposed to a figure of 4.5 vols. percent for the arterio-venous difference in the remainder of the body. In all likelihood, when the oxygen needs of the myocardium are increased most of the gain is achieved by increased perfusion of the coronary arteries instead of widening the arterio-venous oxygen difference.

Sarnoff and co-workers⁸ have shown that as the heart work increases, represented by oxygen consumption of the heart, the closest correlation lies with the tension-time index (T.T.I.). This is defined as the mean systolic pressure times the duration of systole. The other factors such as stroke volume, rate, increased aortic pressure, etc. are undoubtedly contributors to the process that makes the T.T.I. a most accurate means of showing heart work. Chapman et al.⁹ demonstrated in a series of dog studies that stroke volume does increase in response to exercise. Contrary to this point of view, however, is the work of Sjöstrand¹⁰ and Rushmer¹¹ who feel that stroke volume does not increase appreciably.

All of this emphasizes that while we know much about basic physiology of the heart, there is a great deal more to be learned. The foregoing remarks were based on data obtained in the most part from healthy young males and dogs. There are physiologic influences of aging,

sex, environment and training that have an effect on cardiac function.

Some of the most definitive work on the effects of aging on the physiologic response to work have been done by Robinson,¹² P-O Åstrand¹ and I. Åstrand.¹³ The consensus is that when one uses the oxygen uptake as the measure of aerobic work capacity there is a decrease with advancing age. It is uncertain what is responsible for these effects. It is no doubt due, in part, to the decrease in mechanical efficiency. Also, there is a general decrease in functional capacity of various organs, that may be responsible for what controls aerobic work capacity. The effect of age on the pulse response is predicated entirely on whether the work is maximal or sub-maximal. When the work is sub-maximal there is little difference in the response of a young person's pulse and that of an older person. However, as maximal work is done there is a definite decrease in the peak pulse with advancing age. Whereas the 20-year-old may have a pulse of 185 at maximal effort, the 60-year-old will respond with a pulse of 160.

Lactic Acid Response to Work

Wells et al.¹⁴ showed the value of lactic acid measurement in response to work load. They noted that there were three distinct increments of lactic acid response depending upon the degree of work done. This is certainly an anticipated result since lactic acid probably reflects the muscle "effort" involved in working. As maximum effort is reached one would expect high levels of blood lactic acid. Age affects lactic acid levels by showing an increase in absolute levels at maximal work in response to increased age.

Electrocardiographic changes seen with exercise are not constant regardless of age. The percentage of abnormal tracings at both rest and during exercise is increased with increasing age. The changes are probably not a function of any physiologic modification of the aging myocardium, but instead reflect the increased coincidence of actual heart disease in the aging individual. This problem, no doubt, is made even more difficult by varying opinion of what makes up an abnormal electrocardiographic response to exercise.

One point should be made clear in relation to changes of functional responses with advancing age. In almost all studies the deviation from

the mean was great. This indicates that it is feasible for a given 55-year-old to surpass the performance of a given 35-year-old. This individuality of response makes an adequate evaluation of a person's function even more pertinent.

Differences of response secondary to sex have been primarily elucidated by P.-O. Åstrand¹ and I. Åstrand.¹³ The changes are essentially those that might be expected. In women, there is a decrease in maximum oxygen uptake, maximal pulmonary ventilation, maximum aerobic capacity and muscular strength. It is likely that females are less effective "working machines." The pulse rate at sub-maximal levels tends to be higher for females but the response at maximal levels of work is the same for male and female. The same pattern holds true for lactic acid response. With these differences, it is necessary to evaluate women on their own standards and not those of men.

Effects of environment on the physiologic response is profound. A tremendous amount of investigative effort has been directed toward this problem for many years. The relevance to work under varying climatic conditions has been obvious to the military. Lately, with the maturing of industrial medicine, the importance of factory environment in relation to working efficiency has been extensively studied.

Recent work of Brouha¹⁵ shows the effect of temperature and humidity on the work of the heart. One of his studies demonstrates the difference in heart rate at a constant oxygen consumption with one experiment at 72° F and 42% relative humidity as opposed to another experiment with 90° F and 85% relative humidity. Pulse response both during work and in the recovery phase for the latter conditions, showed a marked increase. Burch¹⁶ showed that a hot and humid environment causes an increase in cardiac output primarily by increasing stroke volume, and was apparently able to decompensate a tenuously compensated heart. A further environmental effect has been reported by Åstrand and Åstrand.¹⁷ They report on the effects of prolonged hypoxia on the pulse rate and electrocardiogram. When work was done under hypoxic conditions (14,250 foot altitude) two of the four subjects showed a pulse response that was less than recorded at sea level for a comparable amount of work. When 100% oxygen was given the rate increased imme-

diately. The electrocardiograms showed S-T segment changes and the onset of ventricular premature systoles. They posed the question that chronic anoxia in the cardiac might prevent the heart from attaining the usual physiologic rates.

One of the most nebulous effects on the heart that alters the physiologic state is the reaction of the organism to stress. No one has been able to place stress response on a truly measurable basis. Recently there has been tremendous speculation about the influence of stress, but no concrete data has been forthcoming. Be that as it may, it is wise, as Wolf¹⁸ points out, for the clinician to carefully consider and weigh the effects of stress on his patients and especially those with cardiovascular disease.

Effects of training on cardiovascular response have long been known. There is voluminous evidence that shows the "improvement" of pulse, blood pressure and other parameters in response to training. Aerobic capacity and ability to accumulate oxygen debt are found to increase with training. There is also a tendency to a faster recovery in the trained individual. Pulse response for a submaximal work load is slower in the trained individual; however, the maximal pulse response is found to be the same. It is further noted that these changes are transient in both directions. For example, the untrained individual can improve his performance through a training process, but will revert to pre-training performance if the physical activity is not maintained.

Response of Cardiac

Much of the response of cardiacs to exercise lies in the realm of work yet to be done. Only recently have we been able to assess many of the factors necessary to study an individual's capacity for work tolerance. It is likely that as investigators overcome their natural conservativeness and turn to various disease states, then great strides will be made in understanding the pathophysiologic responses of individuals with cardiac disease. It is impossible to make any broad sweeping generalities about the effects of heart disease on functional ability and capacity. One is forced by the relative paucity of information to study only the specific effects of a specific cardiac lesion.

The work tolerance of many cardiacs is unhindered by their disease. This is recognized if

one recalls the number of people who are working profitably and efficiently and then coincidentally are found to have heart disease. The rationale for this sort of thing is obvious. Most of the occupations that we are subject to in this modern age are at a level of work that is insufficient to produce symptoms and findings in the unsuspected cardiac. Some of the findings of such studies as those done by Hellerstein and Ford¹⁹ would substantiate the idea that the actual caloric demands of most work today is low. Indeed, the leisure hours may provide a far greater demand on the cardiovascular system than that imposed by working conditions. Here, again, it should be stressed, that the total demands on the heart are made up of actual work plus environmental and stress effects. The proper emphasis that the physician will place on these factors is of the utmost importance in the satisfactory adjustment of a cardiac patient to work.

Many authors²⁰⁻²⁷ have gone into detail on the various pathophysiologic changes that occur in response to specific diseases. As stated earlier, no generalization can be made about the hemodynamic changes produced by heart disease, *per se*.

Great strides will be made along these lines as more work comes forth on evaluation of disease states. Until that time we will probably have to be satisfied with the scattered individual reports on specific cardiac lesions.

The work of Holmgren et al.^{28, 29} deserves some special comment since it may clarify one of the distressing problems in clinical medicine. Their work was concerned with a group of patients who gave subjective symptoms of cardiac disease and who were severely incapacitated by these symptoms. Cardiac examination by many parameters revealed normal function except for a very restricted work capacity as measured by the absolute work load with a pulse response of 170, non-specific ST & T wave changes on resting and working electrocardiogram and an elevated pulse in response to an orthostatic test.

The orthostatic test is performed by having the subject lean against a wall for eight minutes and record his pulse at that time. The authors felt that this state, which they termed vasoregulatory asthenia represented a true pathophysiologic condition. While these people were not cardiacs their "cardiac" symptoms prevented them from working. The additional finding of

interest in this series was that the patients responded most satisfactorily to an intensive program of physical training. All patients showed improved capacity to work, even though some continued to manifest their symptoms. While the means of diagnosing and testing for vasoregulatory asthenia are still too esoteric for the practicing physician's office, the interesting concept remains that here is the answer to many a patient that has cardiac symptoms in the absence of cardiac disease.

Thus one can see that in the field of functional evaluation of cardiacs, much practical work has come and will come from the laboratories. The main problem now lies in means of testing that are practical and applicable to the practicing physician.

Testing Functional Capacity

Many methods have been proposed as satisfactory means of placing a value on the performance of the heart. Several of the basic tests have been slightly modified by proponents of one scheme or another so that actually each investigator in the field has his own regimen to follow.

Recently several authors have described some of the various means of testing patients for functional capacity.³⁰⁻³⁶ I will not go into an exhaustive critique on the many methods of exercising the patient. Essentially all the tests have in common the goal of putting the cardiovascular system under some manner of stress. The tests then differ in the method of achieving this end and in the parameters that are measured once the end is achieved.

It might be worthwhile to comment at greater length on the Master two-step test which is probably the most popular means in this country of obtaining some insight into the functional capacity of an individual. There is little doubt that this test puts the cardiovascular system to marked effort. Hellerstein and Ford³⁷ showed that the energy expenditure of performing a Master two-step test was 8.5 calories per minute, which far exceeds the average working load that modern man faces. The main difficulties stem from the fact that there are variable criteria for judging a positive result and also it tends to be an all-or-none test. There is little chance to grade the individual's response other than positive or negative. Any test that permits a

grading of ability to do work would be of greater value.

The linearity of pulse response to work load has been the basis for much of the testing in this field. There is much in favor of a system such as this since the pulse is so readily accessible. One should be cautioned, however, that many environmental and other factors may lead to a false supposition if absolute validity is to be attached to this measure. Any test that is not considering the many changes that occur can be viewed with a certain hesitancy. Since each doctor's office cannot possibly have the sophisticated equipment of a research laboratory, this presents a dilemma. It is unlikely that there is any ready solution to the problem at this time.

In dealing with cardiacs, importance has been placed on the recovery period following a specific amount of exercise. Most people agree that the cardiac will not handle an oxygen debt efficiently and will pay it off at a slower rate during recovery. This is reflected as a prolongation of time until the various measurements return to an approximate resting level. A great deal of insight into the physical capability of a cardiac can be obtained by noting the changes during the recovery phase of exercise.

The logical question arises as to what the practicing physician can do when confronted with the task of evaluating the cardiac's functional capacity. It is obvious from the foregoing thoughts, that no simple regimen is available that will constantly answer the problem. It is of utmost importance to obtain a detailed history of what the patient can do and what symptoms evolve from particular endeavors.

Today we have available many lists and articles on the energy expenditure for a great variety of tasks. Thus, one is able to determine with accuracy how much energy expenditure is symptom-producing in an individual. A cognizance of the environmental and emotional aspects must be kept in mind. Some method of exercising the patient and assessing his response in terms of EKG, pulse, blood pressure and the recovery rate of these parameters will prove to be extremely valuable in many situations. When these "educated guesses" are obtained they will at least provide the physician with something on which he can base a decision as to how much and what kind of activity is available to his patient. In this way it is hoped that many of

the vast numbers of incapacitated cardiac patients can be returned to productive capacities.

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ISMA 1961 MEETING

Indianapolis—Oct. 24-26

These dates are somewhat in conflict with meeting dates of the Indiana State Teachers' Association. All members are urged to make hotel reservations early in order to avoid a shortage of hotel space.

Cardiac diagnosis has been made more complete now that the patient literally may be "wired for sound."

Application of Phonocardiography

ROBERT E. SUESS, M.D.*
Indianapolis

RELATIVELY NEW TECHNIQUES and improved equipment in phonocardiography coupled with the hemodynamic data of cardiac catheterization has allowed a functional understanding of the heart sounds and murmurs of clinical auscultation.^{4, 5} Intracardiac phonocardiography has further clarified knowledge of transmission of murmurs and their site of formation.⁷

The purpose of the present article is the presentation of several examples taken from clinical practice in which the phonocardiograph was of value in either a diagnosis or elucidation of a physiological fact. Additional information will be given relating to the timing of the phonocardiogram and some of its applications not represented here by examples. The phonocardiograms were made with the Sanborn Heart Sound Preamplifier which incorporates a cut-off frequency filter with cut-off frequencies of 25, 50, 100, 200 and 400 cycles per second and a crystal contact microphone. The recording system was the Sanborn Poly-beam recorder. As with the electrocardiogram, the value of the phonocardiogram is increased by serial recordings taken over a period of time.

Phonocardiography is applied to the timing and relationship of the heart sounds and murmurs to each other rather than to any increased perception of faint murmurs because the phonocardiograph is unselective and non-cardiac vibrations may disturb the baseline and thus simulate a murmur. The value of the phonocardiograph is seen in: (1) questions of the timing of murmurs and heart sounds particularly when the heart rate is irregular or rapid; (2) evaluation for and follow-up after cardiac surgery; (3) prognosis; (4) training the physician in clinical cardiac auscultation by correlation of the auditory phenomena with its visual representation.

Other Tracings Simultaneously

To obtain more information than could be acquired from a solitary tracing of the sound itself several other types of tracings are taken simultaneously with the phonocardiogram and are used in this application in timing the events of the phonocardiogram. A discussion of phonocardiography can hardly be separated from a discussion of its methods for timing cardiac events. The most valuable of these are the electrocardiogram, jugular venous tracing, carotid tracing, regional cardiogram and simultaneous sound tracings from two different chest areas.

The information from the EKG in relation to the phonocardiogram is restricted to systole. The use of the electrocardiogram is somewhat limited because of this and because: (1) the

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electrical and mechanical events of the cardiac cycle are variable in their relation to each other; and (2) it cannot help to distinguish between events on the right and left sides of the heart. Changes in the jugular venous tracing parallel the right sided systolic and diastolic events, and the carotid tracing changes are synchronous with left ventricular ejection. The regional cardiogram at the apex (if this is formed by the left ventricle) is representative of left ventricular diastolic events.

Both the jugular venous and carotid arterial tracings are made using a separate type of applicator for the respective pulses and a crystal microphone with a linear response (The Sanborn pulse wave attachment). The applicator for the venous pulse consists of a double rim circular chamber having an internal diameter of 20 mm and a depth of 5 mm. To hold the apparatus to the skin, air is evacuated from the outer chamber by the rubber bulb and tubing to which it is connected. The inner chamber communicates with the microphone through a small hole and short length of rubber tubing. Changes of pressure produced by the venous pulsations in the inner chamber are transmitted to the microphone and converted into an electrical signal that is then amplified and recorded. If the vein is distended, good tracings may be recorded along its length; but if not, the area of the jugular bulb is the best location. The patient's position should be such as to insure the maximum venous pulsation. Generally the right jugular vein is used since it is nearer to the right atrium.

A complete venous tracing may be obtained only with relatively slow heart rates since diastole is abbreviated with the more rapid rates causing superposition of separate waves. The waves recorded are: (1) the a wave, produced by the regurgitation of blood from the right atrium into the veins during atrial contraction; (2) the c wave, thought to be due to right ventricular contraction after opening of the semilunar valves (although some authors state that it is due to impact of the adjacent artery); (3) the v wave, attributed to completion of venous filling of the right atrium while the tricuspid valve is closed; and, occasionally, (4) the h wave, inscribed at the end of complete filling of the right ventricle due to floating of the tricuspid valve. A depression called the x depression follows the a wave and develops

during atrial diastole with lowering of the bottom of the right atrium by right ventricular contraction. Toward the end of the x descent there may be a small notch which is synchronous with closure of the semilunar valves. A second depression called the y depression follows the v waves and occurs with right atrial emptying subsequent to the opening of the tricuspid valve.

Causes of Difficulty

Not all workers agree that transmission of the right sided pressure waves to the jugular vein correlate well enough for a consistently accurate timing of the cardiac events with no appreciably significant time lag. A second cause of difficulty in use of the venous pulse particularly in timing of opening snaps and third heart sounds is that these are usually left heart events while the jugular venous pulse is developed by right heart events. In addition, in a functional or organic tricuspid insufficiency the venous pulse is distorted and the v wave may be delayed on onset.

Notwithstanding these points, the following paragraphs are a brief resumé of venous pulse and heart sound correlations.³ An atrial sound from the right heart will be synchronous with or only slightly precede the summit of the a wave whereas an atrial systolic murmur starts before this summit. An auricular gallop sound occurs at the peak of the a wave. The descending limb of the v wave begins with the opening of the tricuspid valve. In cases of pulmonary stenosis some workers³ have found so constant or nearly constant relationship between the pulmonary component of the second sound and the summit of the v wave (within .04 sec) that they assess the degree of splitting of the second sound from the time elapsing between the aortic component of the second sound and the summit of the v wave in those cases in which the pulmonary component could not be recorded. The end of the y descent coincides with the third heart sound from the right heart and the corresponding sound from the left heart occurs before the y depression.

Recording Carotid Pulse

A small funnel shaped applicator is used to record the carotid pulse. This is pressed firmly by hand against the skin medial to the right sterno-cleidomastoid muscle. Soft rubber tub-

ing connects the lumen of this funnel to the linear microphone (mentioned above for the venous pulse). For purposes of timing the points of interest of the carotid pulse are the beginning of a rapid ascending phase due to ejection of blood into the arteries which represents accurately the time of opening of the aortic valve. Ventricular relaxation then causes a sharp drop in pressure in the arteries which is rapidly terminated by the closure of the aortic valve and produces the incisural notch.

Since the regional cardiogram has not been used in our laboratory only a brief mention of it will be made. It consists of a recording of the slower vibrations due to variations in the motion of the heart against the chest wall at various locations such as the pulmonary or apical region. The apex cardiogram is useful in timing

the third heart sound more accurately than can be done with the venous pulse.

The interval between the first and second heart sounds has been used as a measure of the duration of mechanical systole. The length of systole varies with heart rate but increased sympathetic activity as in cases of thyrotoxicosis or pheochromocytoma produces a shortening of systole out of proportion to the acceleration of heart rate.⁹ The duration of systole in each ventricle may be independent of that in the other; e.g., in inspiration the duration of the right ventricular systole is increased and that of the left ventricle is decreased.

The intensity of the first sound is partially influenced by the position of the AV valves at the time of ventricular contraction which in turn is influenced by inflow of blood into the ventricles during diastole.¹⁰ If the valves are deep within the ventricles (i.e., widely open) they are closed more forcefully for a given force of contraction and thus will produce a louder sound.

Rapidity of Blood Inflow

Several periods of rapidity of blood inflow may be determined during diastole: (1) a period of rapid inflow immediately after the opening of the valves during which the valves are wide open (lasting up to about .21 sec after the preceding second sound); (2) a period of slower flow (occurring in the next 0.1 sec) during which the valves gradually float to a more closed

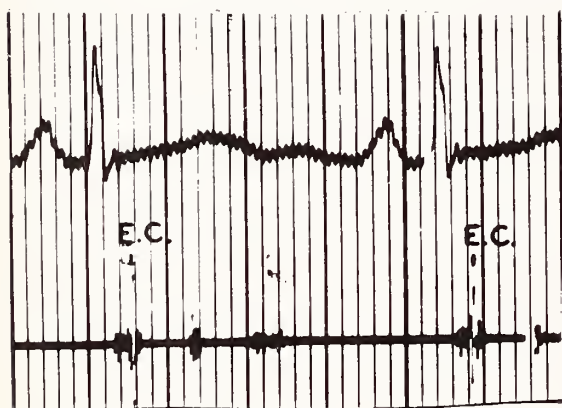


FIGURE 1

56-YEAR-OLD *Negra* female with pulmonary hypertension secondary to mitral stenosis. The tracing was taken at the pulmonic area, and shows an ejection click. Tracing taken with the 100 cps. filter.

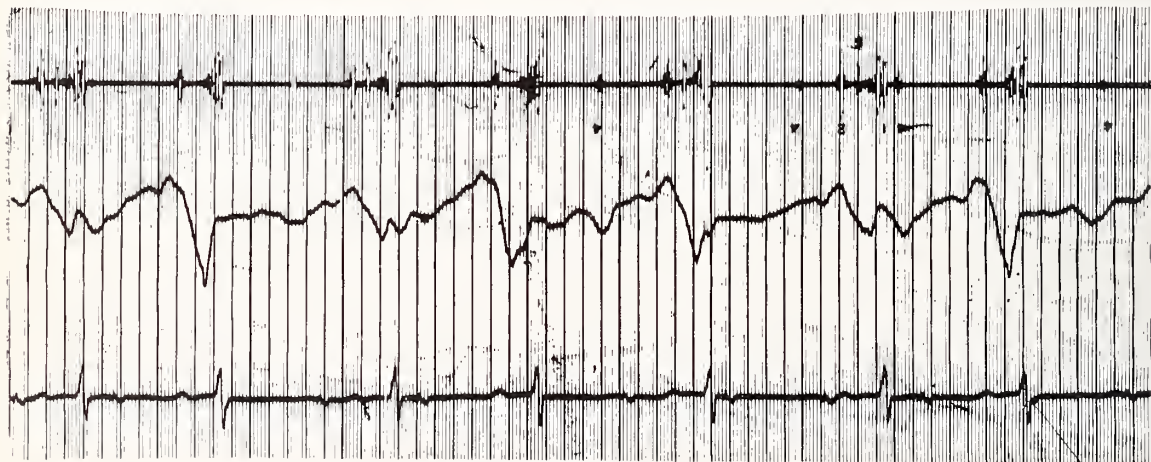


FIGURE 2

87-YEAR-OLD asymptomatic white male with second degree AV block and intraventricular block. This figure shows the presence of a 4th heart sound due to atrial contraction. The first heart sound intensity increases when the P wave of the EKG falls relatively close to the QRS. Tracing taken with the 50 cps filter.

position (if ventricular contraction occurs at this time the sound will be less intense); and (3) a third period during which inflow is again increased because of auricular contraction. This produces greater accentuation of the first sound when the P wave precedes the QRS by .08 to .12 sec. As the P-R lengthens up to 0.2 sec this intensity is diminished but a secondary zone of intensification occurs when the P wave falls over 0.25 sec before the QRS.

The intensity of the first sound is greater in mitral stenosis probably due to increased tension of the valve leaflets but may be reduced if extensive calcification of the valve is present or may disappear after surgery if a significant amount of mitral insufficiency has been produced.

In the differential diagnosis of a split first heart sound which may be a fourth sound and a true first heart sound, the fourth sound always precedes the QRS of the EKG. A phonocardiogram taken with the carotid tracing would show that an ejection click occurs after the onset of the rise (within .03 sec) and splitting of the first sound with any component before this rise would not be an aortic component. Splitting of the first sound due to mitral and tricuspid components is usually very close (.02 to .03 sec apart) and a wide separation may indicate complete right bundle branch block causing a delay in tricuspid closure as much as an additional .03 sec. It may be possible to identify the tricuspid component of the first sound with simultaneous phonocardiograms over the apex and

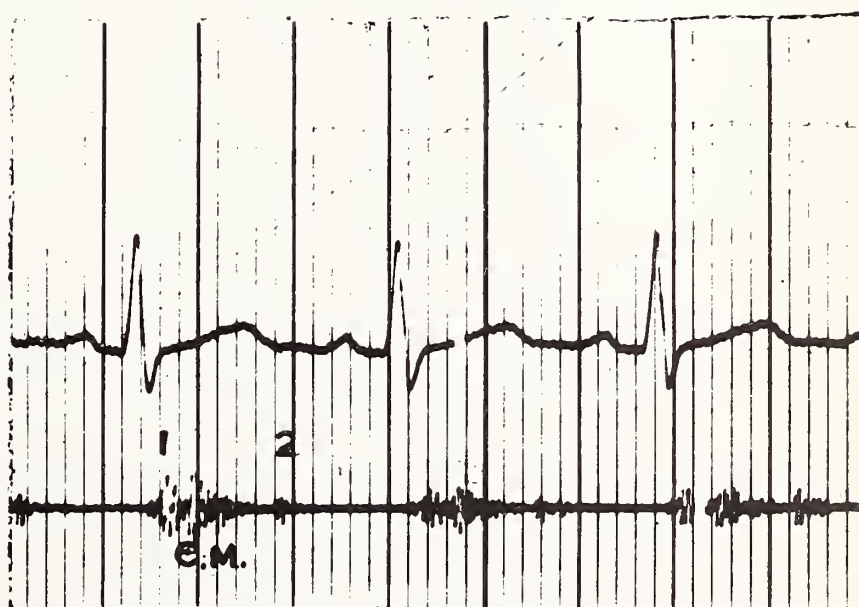
tricuspid areas by its greater intensity in the tricuspid region. Recognition of the tricuspid component is important, particularly when using the Q-1 interval (see below) as an indication of degree of mitral stenosis because it may be mistaken for the mitral component in which case the Q-1 interval would be more normal.

Splitting of the second sound present even on expiration is an abnormal finding and may be due either to: (1) the aortic component occurring earlier due to decreased time of left ventricular systole as in mitral insufficiency and ventricular septal defect (because of diminished resistance to left ventricular outflow); or (2) to delay in pulmonary closure as in RBBB (because of delayed right ventricular activation), and to prolongation of right ventricular systole as in pulmonary stenosis and in atrial septal defect (because of increased right sided flow). The split should be no greater normally than .08 seconds. Splitting in atrial septal defect is relatively fixed and this can probably be appreciated as well by the ear as by the phonocardiogram, but the quantitative determination of the degree of splitting can be made with the phonocardiogram.

When high pulmonary vascular pressure develops and reversal of the left-to-right shunt (e.g. atrial septal defect) occurs, the abnormal splitting of the second sound disappears and is an indication of inoperability. The severity of pulmonary stenosis may be estimated from the width of the splitting of the second sound since there is an approximate linear relationship be-

FIGURE 3

6-YEAR-OLD white male with with a Grade II systolic ejection murmur at the second right interspace accompanied by a systolic thrill. The midsystolic aortic ejection murmur is shown with its typical "diamond" shape that ends before the second sound. (100 cps. filter.)



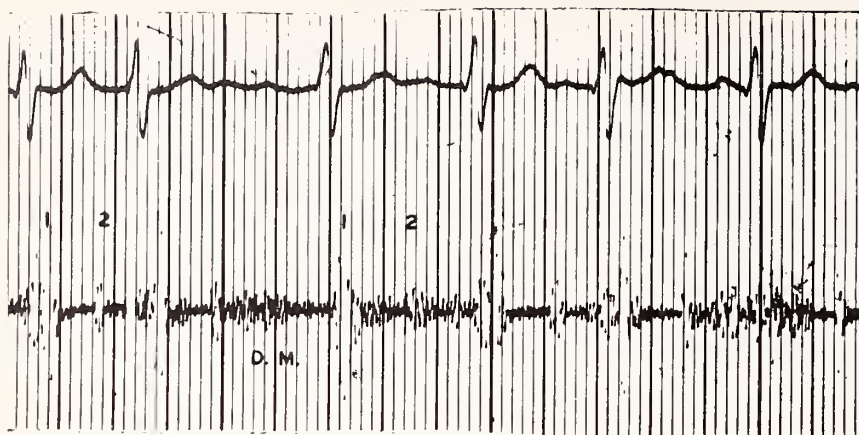


FIGURE 4

30-YEAR-OLD white male with mitral stenosis, aortic insufficiency and auricular fibrillation. The tracing was taken at the apex. Attention is called to the diastolic murmur which becomes more intense with longer diastolic pauses. No particular presystolic accentuation occurs because the patient has auricular fibrillation. The Q-1 interval is also seen to decrease with the longer diastolic pauses. (100 cps. filter.)

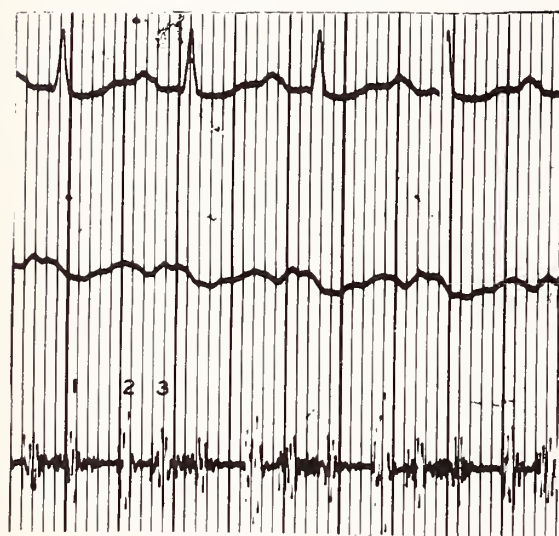


FIGURE 5

46-YEAR-OLD Negro male with arteriosclerotic heart disease in congestive heart failure at the time of the tracing. On auscultation a diastolic gallop alone was heard but the tracing shows the third heart sound of a gallop followed by a ventricular diastolic filling murmur. (50 cps. filter.)

tween delay of the pulmonary component of the second sound and the right ventricular systolic pressure.⁵ The degree that splitting of the second sound decreases after successful surgery is thus useful for follow-up after surgery.

Since the pulmonic closure sound is normally not heard at the apex or is much reduced, the timing and identification of aortic and pulmonic components of the second sound may be made by simultaneous sound tracings taken at the apex and pulmonic areas of auscultation. The carotid tracing offers additional timing for aortic closure.

Second Sound Splitting

A so-called paradoxical splitting of the second sound in which there is narrowing of the

interval of splitting on inspiration instead of the usual widening will occur because the aortic component is delayed and occurs after the pulmonary component. On inspiration the pulmonary component behaves as usual by delayed occurrence but now it precedes the aortic component so there is narrowing of the interval. This may be due to delay in aortic closure as in LBBB (because of delayed left ventricular activation) and aortic stenosis; or to increased left ventricular flow as in patent ductus arteriosus with left-to-right shunt.

In mitral stenosis the opening snap may be near enough to the second sound to be confused as its pulmonary component. A simultaneous phonocardiogram from the left lower sternal edge and the pulmonic area will demonstrate both aortic and pulmonary closure and the opening snap. The greater the degree of stenosis (and thus the higher the left atrial pressure), the nearer will the opening snap fall to the second sound; i.e. the shorter will be the S_2 -o.s. interval. In mixed mitral stenosis and insufficiency the addition of the venous tracing may be useful in delineating aortic and pulmonary closure, the opening snap and a third sound for all these events occur within an 0.2 second interval. The occurrence of the opening snap itself indicates the presence of sufficient valvular flexibility to consider the case for operation. A third heart sound or early diastolic gallop rhythm present with mitral stenosis implies a rapid left ventricular filling and indicates that there is an accompanying mitral insufficiency.

As an indication of a successful mitral commissurotomy, the phonocardiogram is of objective value since the delay of onset of the first heart sound seen in mitral stenosis is reduced

by the decrease in left atrial pressure attending the valvulotomy. The presence of the delayed first sound is indicated by a Q-1 interval (interval from onset of QRS of EKG to the large rapid deflections of the first heart sound) over its normal value of .02 to .06 sec. This delay is attributed to incomplete filling of the left ventricle during diastole as a result of the reduced blood flow through the stenotic orifice. Other factors influencing the Q-1 interval are the P-R interval in sinus rhythm and the length of the preceding diastole in auricular fibrillation. The S₂-o.s. interval may be longer following successful surgery since decreased left atrial pressure causes later opening of the A-V valves.

The same intervals have been used to assess the severity of the stenosis by Wells.¹² When the Q-1 interval minus the S₂-o.s. interval was minus 1 (or more positive), severe stenosis was indicated; but if more negative than minus 1.5, then the mitral orifice was greater than 1 sq. cm. and the stenosis was not considered severe.

The delayed first heart sound indicated by a prolonged Q-1 interval has also been noted in patients with hypertension and helps to explain the occurrence of an atrial gallop rhythm in some cases of hypertension.¹¹

Differentiating Murmurs

The phonocardiogram may be of help in differentiating the mid-systolic ejection murmur due to flow through the aortic or pulmonary valves from the pansystolic murmur due to AV valve insufficiency, ventricular septal defect or patent ductus arteriosus. The ejection murmur should have a typical "diamond" shaped appearance ending before the closure of the appropriate semilunar valve which may not be appreciated by the ear.

Differentiation of the aortic from the pulmonary ejection murmur may be made in cases in which the pulmonary ejection murmur drowns aortic closure since the murmur would still end before the pulmonic component of the second sound and the use of the carotid tracing allows its location within the murmur to be noted. An aortic or pulmonary systolic murmur accompanied by a diastolic murmur might be confused by the ear with a continuous murmur of a patent ductus but the phonocardiogram would show its systolic component disappeared before semilunar valve closure. The loud pansystolic murmur due to mitral insufficiency may over-

whelm the sound of aortic closure so that a third heart sound would be mistaken for the second sound and the pansystolic murmur would then be considered to be an ejection murmur.

The diastolic murmur of aortic or pulmonary insufficiency should begin immediately after the corresponding semilunar valve has closed, whereas the ventricular diastolic filling murmur seen with increased ventricular filling flow as in mitral insufficiency and left-to-right shunts follows the opening of the atrioventricular valves (and thus with some delay after the second heart sound). These filling murmurs are always short since there is increased flow but no prolongation of the rapid filling phase as in mitral stenosis. The length of the diastolic filling murmur is of importance in evaluating a chronic rheumatic valvular case for surgery since the murmur must be long to indicate prolongation of the phase of ventricular filling and appreciable stenosis. In addition, this same point is of help in deciding whether a patient has acute or chronic valvular disease since a shorter murmur may be simply due to increased flow or a roughening of the valve. However, the phonocardiogram is valuable only if the length of diastolic pauses are of sufficient length to allow the murmur to develop its full length.

Due to an auditory illusion the presystolic murmur of mitral stenosis may sometimes be simulated by a first heart sound alone. The phonocardiogram is of value in such a case by exhibiting the actual lack of a presystolic murmur.

In summary this article has: (1) described methods of timing of phonocardiography; (2) presented some of the correlations of phonocardiography to clinical problems; and (3) presented examples of phonocardiograms illustrating a few of the principles mentioned in the body of the article.

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Smog—East and West

Disastrous air pollution episodes such as occurred in Donora in 1949 and London in 1952 are fortunately rare. They require unique meteorologic and chemical air combinations which are not very well understood. Equally obscure is the very vital point of whether sublethal concentrations of any air pollutant in prolonged exposure can cause chronic effects on the cardiorespiratory system and other body functions. As the air continues to become even more polluted, research is also building up on these and related problems.

Thomas separated two types of smog, London and Los Angeles variants. The London type smog, similar to that in the New York-New Jersey area, is a complex, including coal smoke associated with a considerable amount of sulfur dioxide. Furnaces of all types would seem an obvious source. By contrast, the Los Angeles type smog contains neither coal smoke, fog nor significant amounts of sulfur dioxide. It is made up of hydrocarbons of automobile exhaust origins.—*Am. J. Pub. Health*, 49:1664, 1959.

All that sparkles is not normal . . .

Bacteriuria in a Group of Patients with Hypertension

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AN IMPORTANT ENIGMA in the differential diagnosis of hypertension is the question of frequency of pyelonephritis as either a primary or complicating disease process. A considerable discrepancy exists between the frequency at which the diagnosis of pyelonephritis is made in autopsy studies and the clinically diagnosed incidence in hypertensive patients. It is apparent that the presence of infection in the urinary tract is often overlooked when reliance is placed solely on symptomatology and routine urinalyses.

Studies of Beason,¹ Kass,²⁻³ MacDonald⁴ and others have shown that a quantitation of the number of bacteria in urine provides a sensitive means of detecting active urinary tract infection. Extensive studies by Kass⁵ in over 4,000 patients have indicated that the finding of 100,000 or more bacteriuria per milliliter in a single urine sample distinguishes contamination from true bacteria with a confidence limit of 95% if the sample is catheterized and 80% if voided.

The subject of this report is the bacteriologic findings in the urine of 103 *female* hypertensive patients seen in the Medicine Clinic of Marion County General Hospital, none of whom had symptoms of urinary tract infection.

Methods

The procedure for obtaining urine samples was as follows:

The perineum was prepared by cleansing with soap and water as for catheterization and the patient was instructed to void first into an unsterile container and then into a sterile one in such a manner as to avoid contact of the urine and the external genitalia.

As soon after voiding as possible, the urine was taken to the bacteriology laboratory where blood agar and media selective for staphylococci and for gram negative organisms were plated. Quantitative platinum loops, one designed to transfer .01 milliliter of urine and the other .001 milliliter of urine, were used for plating. The number of bacteria colonies present after 24 hours incubation at 37°C were counted.

Results

As indicated in Table I, in 65% of the urine samples obtained, the colony count was 10,000 per milliliter or less. A significant bacteriuria (100,000 colonies or more per milliliter) was detected in 24 patients or 23% of the patients studied. It is to be noted that relatively few of the counts fell in the 10,000 to 100,000 range.

Staphylococcus albus, a common contaminant, was cultured as the only organism 24 times, but in all but four of these cultures the total number of organisms present was 1,000 or less. In no instance were more than 20,000 colonies of *Staphylococcus albus* per milliliter found. Aero-

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(With the assistance of Rebecca Dragos, A.M. Pauline Shull, R.N.)

Culture Results	Number of Patients	Incidence
No Growth	24	65%
100 - 1,000	34	
1,000 - 10,000	9	
10,000 - 100,000	12	12%
100,000 or more	24	23%

TABLE I

bacter aerogenes was the sole organism in five cultures. *Escherichia coli* grew out in pure culture from eight urine samples, and in all of these instances the organisms were present in numbers greater than 100,000 per milliliter.

Gram negative organisms were cultured from nine of 43 urines with counts of 100 to 10,000 per milliliter; gram negative organisms were present in 18 of the 24 urines showing counts greater than 100,000. Thus, it is seen in patients with a significant level of bacteriuria (more than 100,000 per milliliter), gram negative organisms appeared most frequently in contrast to the predominance of gram positive bacteria from those urines with an insignificant total number of organisms.

When those patients with significant bacteriuria were compared with those negative in this respect, no significant difference was apparent in duration and severity of hypertension or blood urea nitrogen levels. The mean age of this group of patients was 58.

Discussion

Finding of 24 instances of significant bacteriuria (more than 100,000 per milliliter) in a group of female hypertensive patients unsuspected of having a urinary tract infection would at least suggest that symptomatology and routine urinalyses are not sufficiently sensitive means of detecting this disease process. Further study and follow-up of these patients is necessary for the assessment of the relationship of their hypertension to the finding of bacteriuria.

The bacteriologic findings in this study are in agreement with those of Kass in that high counts were seldom due to *Staphylococcus albus*, diphtheroids or other common contaminants. High counts on the other hand were most frequently attributable to common pathogens of the urinary tract.

Kass has reported that in 337 female patients in the medical out-patient department, bacteriuria was present in six percent. Eighteen percent of 54 diabetic female patients were found to have significant bacteriuria. The incidence of 23% in

the presently reported group of hypertensive female patients was surprisingly high.

For routine studies in hypertensive patients, it is reassuring to find that a clean voided midstream sample in the female patient is almost as satisfactory for diagnostic purposes as a catheterized specimen. It is well recognized that even a single catheterization procedure is not without risk of inducing a urinary tract infection. Kass has stated "It is no longer necessary, except in very unusual circumstances, to obtain a catheterized specimen from females or from children for bacteriologic study of the urine."⁵

In situations in which quantitative urine cultures are not available, obtaining a urine specimen in the manner outlined, centrifuging approximately 10 cc. of the urine in a tapered-tip centrifuge tube, removing the supernatant and transferring approximately 0.1 cc. of sediment to roughly one square cm. area of a microscopic slide, and preparing a gram stain of the sediment provides a fairly satisfactory substitute. If one finds bacteria on such a preparation, the significance is the same as finding 100,000 bacteria per milliliter or more on culture.

It should be emphasized that urine is a good culture medium for most bacteria and that a considerable increase in bacterial content can occur even at room temperature if the urine is let stand for longer than one hour.

Conclusions

1. Approximately one-fourth of a group of female hypertensive patients without urinary tract symptoms were found to have more than 100,000 bacteria per cubic milliliter of urine in a clean voided midstream sample.

2. Quantitative bacteria counts, using volumetric platinum loops for inoculation of agar plates provides a relatively simple means of studying patients for significant bacteriuria.

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Quinidine in the Treatment of Cardiac Arrhythmias

A highly useful drug for which strict safety regulations are required.

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THE PLACE OF QUINIDINE in the therapeutic armamentarium is defined vividly by Goodman and Gilman.¹ They state, "nevertheless, when quinidine is used it must be employed with a great deal of knowledge, for it is a dangerous as well as an effective drug." The present communication is by no means intended as a review of the subject but will merely serve to focus our attention on the more important aspects of quinidine therapy and at the same time permit us to review some of the problems which we have encountered in the course of the past few years. Needless to say, we feel that quinidine is an extremely valuable drug and should be used without hesitation when the occasion arises.

Quinidine is an alkaloid of cinchona bark and an optical isomer of quinine. Its major and most significant effect is on the myocardium and this is manifested by depression of excitability, conductivity and prolongation of the refractory period. It is the change in refractory period of cardiac muscle that is responsible for abolishing

the ectopic arrhythmias.² The exact manner by which the refractory period is prolonged is not as yet entirely clear, but two pieces of information are in keeping with the observed effects of quinidine. The vagolytic effect of the drug reverses the tendency of the vagus to shorten the refractory period and accelerate conduction and by this inhibition of vagal effect prolong the refractory period and slows conduction. Recent electrophysiological studies³ indicate that quinidine interferes primarily with entry of sodium into the cell. In addition, by altering the permeability of cell membrane to potassium it interferes with efflux and influx of the cation through the cell membrane. There is also some evidence to indicate that the action of the "sodium pump" is similarly depressed. These findings explain the slowing of conduction and prolongation of the recovery period, with resultant EKG manifestations of prolonged QRS and the Q-T interval.

Quinidine has been used successfully for the treatment and occasionally for prevention of atrial premature systoles, tachycardia, flutter, fibrillation, A-V nodal tachycardia, ventricular premature systoles and ventricular tachycardia. There is still some disagreement as to indications and contraindications for the use of this drug.

There is certainly unanimity of opinion that the drug should be used to control ventricular

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tachycardia and multiple ventricular premature systoles complicating acute myocardial infarction. As far as conversion of atrial fibrillation is concerned one would find little objection to use of quinidine where (1) the fibrillation is of recent origin or (2) does not cease spontaneously after successful treatment of the underlying cause, such as thyrotoxicosis or mitral stenosis. On occasions conversion of atrial fibrillation to S-A rhythm in patients with intractable heart failure may improve the situation some by increasing the cardiac output.

7 The drug is of questionable value, however, in preventing recurrent attacks of atrial fibrillation or ventricular prematures which may follow acute myocardial infarction. Occasionally quinidine may control repetitive bouts of atrial tachycardia, but even here digitalis seems to be preferred by many physicians.

Contraindications Are Few

Absolute contraindications for the use of quinidine are few. Allergic reaction and presence of a complete heart block, where the patient's survival depends on the presence of an ectopic focus, seem to be the only ones. Many factors, however, such as age, severity of the heart disease, degree of congestive heart failure, conduction defects and intercurrent infections markedly increase the hazards of quinidine toxicity.

13 gm
2
The methods of administration of quinidine in our hospital are based largely on the studies of Sokolow⁴ who through extensive investigation correlated the blood level of quinidine with various doses and dose schedules. Quinidine is given in one of two ways. The intravenous route is used for termination of arrhythmia in critically ill patients, and the oral route either for conversion of arrhythmia to sinus rhythm or for maintenance of the sinus rhythm. The intravenous route is used almost exclusively for the management of ventricular tachycardia accompanied by signs of heart failure and/or shock. The drug (0.8 gm) is diluted in 150 cc of saline and given slowly over a period of 45 minutes. This procedure is monitored with an EKG and more recently with an oscilloscope and the patient is observed for signs of hypotension. The drug is discontinued if the duration of QRS increases by 50%. If conversion fails, the same procedure is repeated in two hours, be-

cause at that time the drug has reached peak level. In our hands this method has been most satisfactory.

Oral Method for Conversion

With the exception of an occasional case of ventricular tachycardia without heart failure or circulatory collapse, the oral route is used primarily for conversion of atrial arrhythmias to sinus rhythm. We begin by giving 0.2 or 0.3 gm of quinidine every two hours for five doses. On the next day the dose is increased to .3 or .4 gm every two hours for five doses. This increment by .1 gm per dose on subsequent days is followed until the individual dose reaches .8 gm every two hours.

It has been our experience, as well as that of others, that the yield of satisfactory conversions when the individual dose had to exceed .6 gm is relatively small and the incidence of toxic side effects rises steeply. We are in a fortunate position in being able to obtain quinidine blood levels at the Lilly Laboratories for Clinical Research and with such a guide, less attention need be paid the actual quantity of drug administered provided the range of quinidine in the blood is kept between 6 and 8 mg per liter. The basis for the use of 5 two-hourly doses is Sokolow's⁴ observation that after the fifth dose the blood level does not rise unless the amount of the drug is increased or the same dose given more frequently.

Maintenance therapy is used to prevent the recurrence of successfully abolished arrhythmias. The starting dose is usually .2 gm given four times daily. With such a schedule, peak blood level is reached in about 72 hours at which time, the dose may be adjusted depending on the patient's response to the treatment.

There is still some controversy about the dangers of simultaneous use of digitalis and quinidine. In our hospital quinidine is never used in treatment of supraventricular arrhythmias unless the patient is first fully digitalized. We believe the reasons for the combined use of the drugs in clinical practice to be quite sound. Serious difficulties may be encountered as result of administration of quinidine to patients whose A-V conduction is not depressed by digitalis. Slowing of the rate of atrial flutter combined with the vagolytic effect of drug may be sufficient to change the atrio-ventricular block from 2:1 or 4:1 to 1:1 with resultant rapid

ventricular rate, usually over 200 beats per minute which throws an added burden on the already damaged heart.

Not infrequently flutter will first be changed to fibrillation before being converted to sinus rhythm. If the patient is poorly digitalized and at the same time the vagal effect is inhibited by quinidine, with onset of fibrillation the ventricular rate may become extremely rapid and deterioration of circulatory status may then ensue. The same arguments are applicable to any non-digitalized patient with atrial fibrillation receiving quinidine.

Success Dependent on Three Factors

Success of quinidine therapy depends on the nature of the arrhythmia, etiology of underlying heart disease and the duration of the disturbance. For example (1) atrial fibrillation due to arteriosclerotic heart disease is as a rule easier to convert to sinus rhythm than if the arrhythmia were due to rheumatic mitral insufficiency, (2) atrial flutter is much more resistant to quinidine than is atrial fibrillation, (3) arrhythmia of short duration responds more readily to treatment than one of long standing but on the other hand (4) an attempt to prevent recurrent atrial fibrillation usually meets with failure.

The experience of Sokolow⁵ and his group is fairly representative of the general problem of quinidine therapy of atrial fibrillation. These workers found a conversion rate of 74% in 214 attempts in 177 patients with atrial fibrillation. Conversion of atrial fibrillation was less likely if the arrhythmia was present six months or longer, was due to rheumatic mitral insufficiency or was accompanied by heart failure and embolization. The average blood level of quinidine at which conversion occurred was 6.1 mg/L and this was accomplished with an average of 2.2 gm of the drug per day. Eighty-five percent of conversion occurred with less than 3 gm of quinidine per day and a level of 8 mg per liter or less. Myocardial toxicity was infrequent at levels less than 6 mg per liter. According to these authors relapse of atrial fibrillation occurred in 85% of the patients who were not placed on maintenance therapy, but in only 20% if they were given 1.6 gm of quinidine per day which was sufficient to maintain a blood concentration of the drug of over 60% of the therapeutic level.

Atrial Flutter Hard To Treat

The majority of physicians will agree that

atrial flutter is most difficult of all the arrhythmias to treat. The majority of failures over the years in our institution have occurred when conversion of atrial flutter was attempted.

Toxic manifestation of quinidine include allergic reactions, fever, thrombocytopenia, nausea, vomiting, diarrhea, tinnitus, vertigo and hypotension. Serious toxic effects are those related to the heart and are manifested by depression of impulse formation and conduction and recovery of excitability. Paradoxically, ectopic ventricular rhythms have been occasionally ascribed to quinidine. It is true that myocardial depressants such as quinidine, procaine amide, potassium and digitalis, by unequal depression of myocardium, give rise to ectopic foci. However, in clinical cases of aberrant ventricular conduction simulating ventricular tachycardias these are more likely rapid supraventricular arrhythmias with aberrant conduction rather than ventricular ectopic rhythms.

The danger of embolization with sudden death in course of conversion has been overemphasized in the past. Thompson⁶ reporting combined experience with quinidine in 611 patients found 20 instances of sudden deaths (3.3%). In certain cases the death could be clearly attributable to other causes reducing the mortality rate presumably due to quinidine to 2.1%. Discussing the sudden cause of death in this group, the author states, "However, valid conclusions regarding the cause of sudden death cannot be drawn from the limited necropsy data available; similarly, the inference of cerebral embolism does not seem warranted in view of these limitations." Irrespective of yet unsettled problems of embolization in the course of or as a result of quinidine therapy, embolization per se should not be considered a contraindication, but to the contrary, an indication for attempted conversion.

The toxic effects of quinidine on the myocardium can be frequently reversed with molar lactate.⁷ However, on animal studies Wasserman⁸ and his associates found that, "molar sodium lactate does not appear to alter the ultimate fate of animals severely poisoned with quinidine." The exact mechanism of lactate action is unknown, but it has been suggested that the lactate replaces glucose and fructose, the latter being "inhibited" by quinidine, and enters directly into the Krebs cycle and by this mechanism improves the metabolism of the cell. This point remains to be settled.

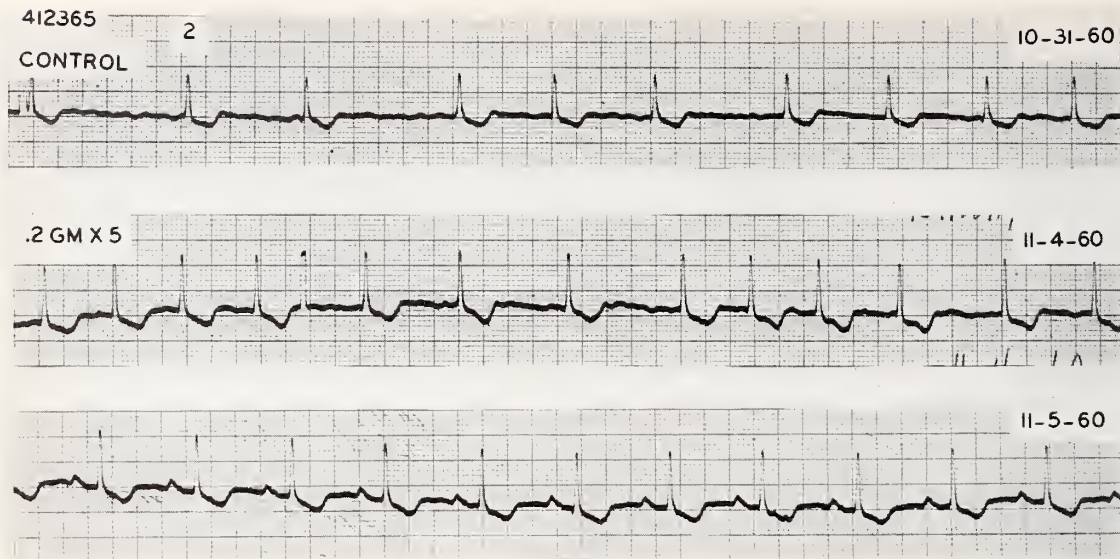


FIGURE 1

SUCCESSFUL CONVERSION of atrial fibrillation to sinus rhythm. Please note the decrease of A-V block and acceleration of ventricular during administration of quinidine (11-4-60). For details see text.

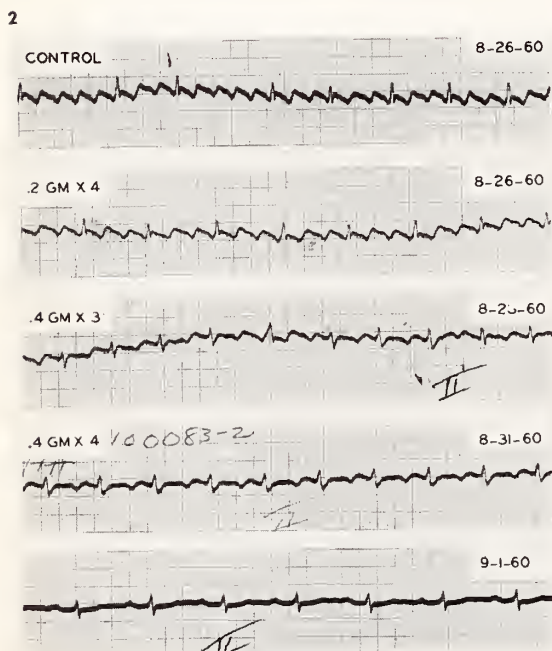


FIGURE 2

SUCCESSFUL CONVERSION of atrial flutter. Please note the gradual slowing of atrial rate with diminution of the degree of A-V block and parallel acceleration of the ventricular rate. For details see text.

Case Illustrations

In the succeeding part of the paper we will present cases illustrating some of the points discussed above. All the cardiograms were taken from the files of the Robert M. Moore Heart Clinic and the quinidine levels were determined at the Lilly Laboratory for Clinical Research.

From 9-21-59 to 9-24-59:
Digitoxin 1.3 mg
Quinidine 0.8 gm

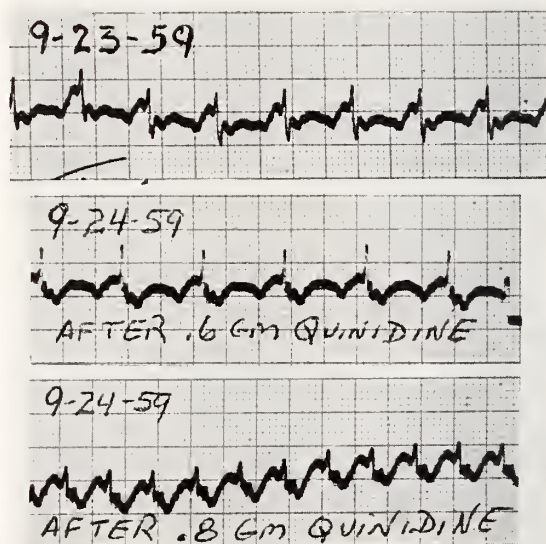


FIGURE 3

EFFECT OF SLOWING of atrial flutter coupled with the vagolytic effect of quinidine on the A-V conduction in an incompletely digitalized individual. Note that the ventricular rate increased from 150-230 in course of administration of the drug. For details see text.

Figure 1. A 35-year-old woman underwent a mitral commissurotomy in July 1959. She had had transient episodes of atrial fibrillation since that time, the arrhythmia becoming permanent sometime in July 1960. The patient was thought to be fully digitalized on admission to the hospital on 9-27-60. Control tracing (10-31-60)

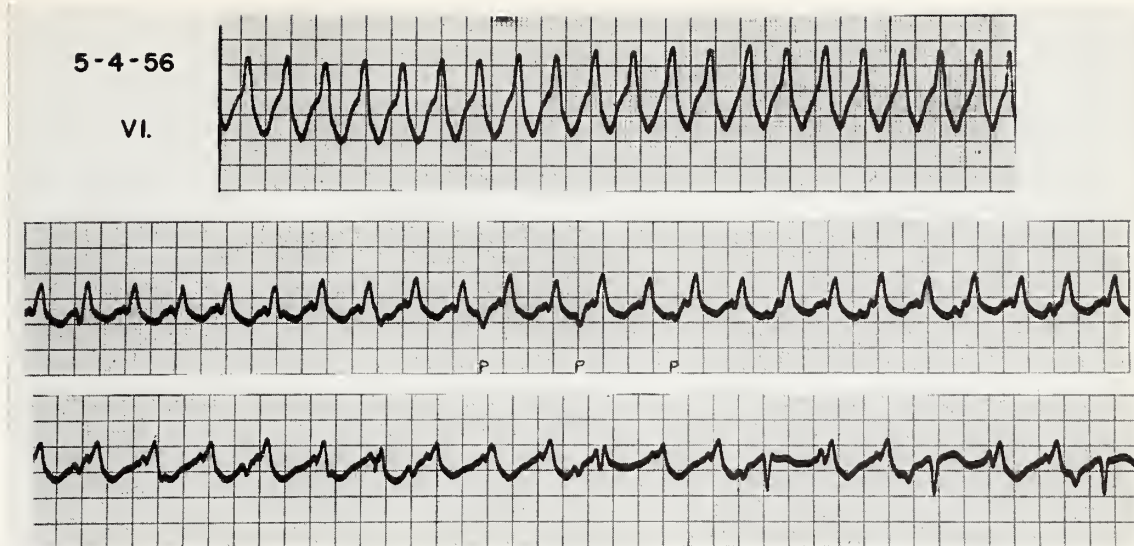


FIGURE 4

GRADUAL SLOWING of a ventricular tachycardia under the effect of quinidine with appearance of ventricular fusion and capture. For details see text.

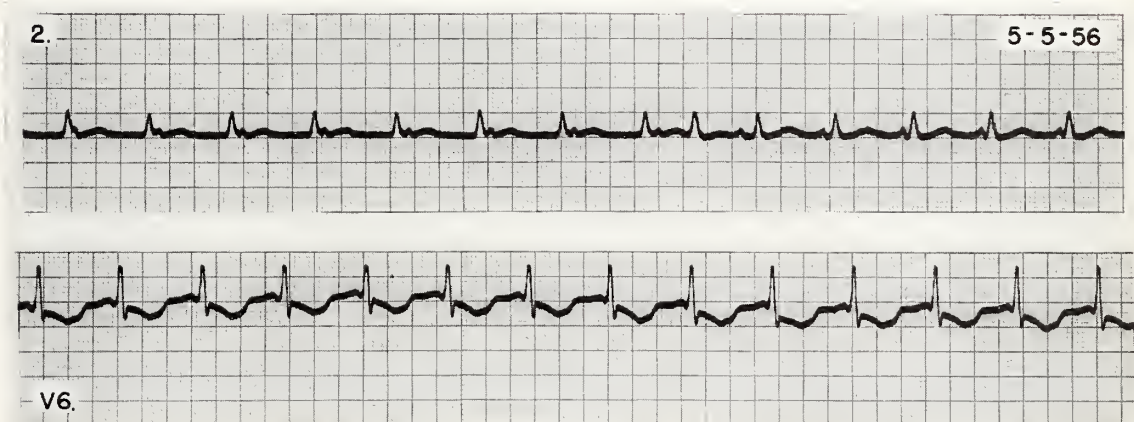


FIGURE 5

THE SEQUEL to Figure 4 demonstrating A-V dissociation in upper strip with normal sino-atrial rhythm in lower strip and a marked prolongation of the Q-T interval.

obtained before quinidine was given shows an atrial fibrillation with a ventricular rate of approximately 60 beats per minute. Conversion (11-5-60) occurred after only 1.0 gm of quinidine was given on 11-4-60. Please note that the ventricular rate accelerated during administration of quinidine probably exhibiting the vagolytic effect of the drug. The ease with which conversion took place can be accounted for by the rather short duration of established arrhythmia (less than six months) as well as to absence of mitral insufficiency. Sokolow⁵ found that mitral stenosis *per se* not accompanied by significant insufficiency does not make conversion more difficult.

Figure 2. A 48-year-old male was admitted because of a large saccular aneurism of the ascending as well as descending portions of the aorta, but without involvement of aortic valves or valve ring. The rhythm on admission was one of atrial flutter. He was fully digitalized on admission and it was decided to attempt to convert the flutter to sinus rhythm. The control tracing shows the atrial flutter with a rate of 280 and a ventricular response of 3:1 and 5:1. After quinidine was started the atrial rate decreased to 240 and the block stabilized at 3:1. With further increase of quinidine and slowing of atrial rate to 210 on 8-28-60 and 200 on 8-31-60 the block was reduced to 2:1 and the

ventricular rate increased from 75 on 8-26-60 to 100 on 8-31-60. Sinus rhythm was established on 9-1-60. This case serves to illustrate the slowing effect of quinidine on atrial flutter. Were the patient not digitalized, it may well be that with slowing of the atrial rate to 200, the ventricular response would have been 1:1 and the patient's condition worsened by the sudden increase of the ventricular rate from 75 to 200.

Figure 3. A 56-year-old man with total anomalous venous return was admitted with persistent atrial flutter and a rapid ventricular rate. In spite of administration of large doses of digitalis and quinidine the A-V response persisted at 2:1 and conversion was never accomplished. Quinidine had to be discontinued after 2.4 gms were given in one day because the QRS showed a 50% increase in width over the control tracing. The purpose in showing this tracing is to emphasize the danger inherent in administering quinidine to an incompletely digitalized patient with atrial flutter. The control tracing on 9-23-59, shows atrial flutter with an atrial rate of 300 and a 2:1 response (ventricular rate 150). After 0.6 gm of quinidine was given the atrial rate slowed to 230 and this coupled with the vagolytic effect of the drug, resulted in a 1:1 response and rapid deterioration in the patient's condition.

Ventricular Tachycardia Termination

Figures 4 and 5 are an example of successful termination of ventricular tachycardia. The patient was treated with oral quinidine. The upper tracing in *Figure 4* shows abberant ventricular complexes at a rate of 190 per minute and regular. Definite differentiation from supraventricular tachycardia with abberant conduction is impossible. With ventricular slowing (strip 2) an independent atrial rhythm at a rate of 75 is clearly visible. This gives further support to a diagnosis of ventricular tachycardia; however, an A-V nodal tachycardia with retrograde block, independent atrial rhythm and abberant intraventricular conduction cannot be ruled out.

With further slowing of the ventricular rate, in addition to the independent atrial rhythm, fusion (combination) and capture beats are clearly visible. These are illustrated by the eleventh and fourteenth QRS complex respectively. Complexes 17 and 20 also represent ventricular activation by atrial impulses (captures). The effect of quinidine in this particular tracing was one of slowing of the ventricular rate. This alone at times may be sufficient to in-

crease the cardiac output and allow for some delay of further attempts at conversion. In *Figure 5* the ultimate cessation of ventricular tachycardia is demonstrated. In the upper row a rather unusual effect of quinidine therapy, namely A-V dissociation, is present. Please note the normal appearing QRS complexes with independent atrial rhythm. In second row S-A rhythm was recorded with a rather striking prolongation of the Q-T interval.

Figure 6 was recorded in a 13-year-old boy who experienced repeated episodes of atrial tachycardia since birth. The present episode started on 10-20-57 and failed to respond to toxic doses of digitalis. The possibility of an underlying Wolff-Parkinson-White was then considered and the patient placed on quinidine. After a total of 2.5 gm of the drug given in two days tachycardia ceased and W-P-W syndrome became apparent. Tracing taken on 10-29-57, shows a short P-R interval, abberant QRS with slurring on the upstroke (Δ wave). In some cases of W-P-W the Δ wave is negative in leads III and AVF, and may be mistaken for a posterior myocardial infarction. The exact cause for increased incidence of atrial tachycardia in W-P-W is not clear. In some instances the arrhythmia may be propagated by a circus movement, using both the anomalous bypass (bundle of Kent) and A-V node to bridge the atria and ventricles. Quinidine, having a depressing effect on the muscular bundle of Kent, breaks the circus movement and thus abolishes the arrhythmia.

We have been very much interested in the so-called ventricular tachycardia due to quinidine which in clinical cases may actually be of supraventricular origin with abberant ventricular conduction. The next three cases represent rather severe myocardial depression manifested by abberant intraventricular conduction. The latter when associated with rapid rate may be easily mistaken for ventricular tachycardia. Needless to say in none of the three cases was successful conversion accomplished. The quinidine was discontinued because of the serious myocardial depression.

Attempt at Atrial Flutter Conversion

Figure 7 illustrates an attempt at conversion of atrial flutter. The patient was admitted on 3-7-60, because of acute myocardial infarction as shown in upper two rows of this figure. The QRS became prolonged, measuring 12 seconds

10-25-57

10-28-57

10-29-57

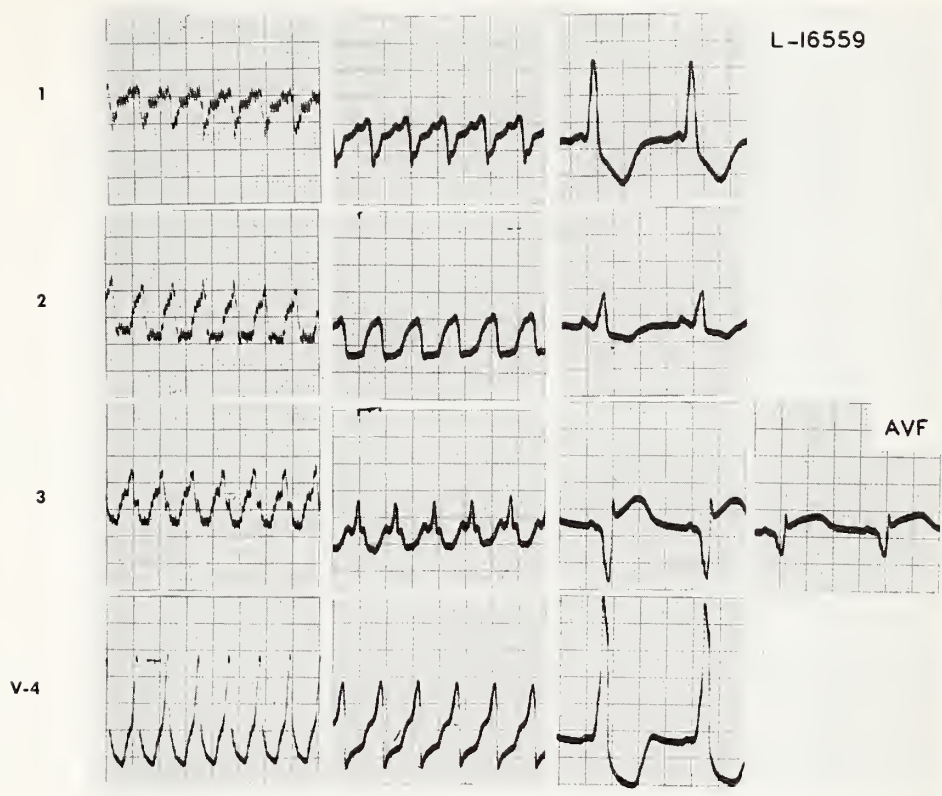


FIGURE 6

TERMINATION OF PAROXYSMAL atrial tachycardia with quinidine in a patient with an underlying Wolff-Parkinson-White Syndrome. For details see the text.

with morphology of left bundle branch block (tracings shown). Upon appearance of atrial flutter prompt digitalization was accomplished but with failure to slow the ventricular rate it was elected to start quinidine. The control tracing (3-14-60) shows atrial flutter with a 2:1 response. The exact duration of the QRS cannot be evaluated in this particular lead (lead II) because the "f" wave merges with the terminal portion of the QRS. From other leads, however, the QRS, as was pointed out above measured 0.12 sec. After administration of 1.0 gm of quinidine (0.2 gm every 2 hours x 5 doses), the plasma level was 3.7 mg per liter and the QRS showed further prolongation and change in the direction of the mean vector (3-15-60). Quinidine was promptly discontinued with return of the cardiogram to control state (3-16-60). Although serious toxicity infrequently appears at levels of quinidine below 6 mg per liter, such instances have been observed by others.

Figure 8. These tracings were obtained from a 70-year-old man with known coronary heart disease and complicating lobar pneumonia. In an attempt to control his fibrillation (5-8-52) digoxin was administered. After a total of .8 mg was given quinidine was started in an attempt to establish sinus rhythm. Tracing of 5-13-52 was recorded after 0.8 gm of quinidine was ingested by the patient. cursory inspection would make one consider ventricular tachycardia. That this is not the case is indicated by (1) prolongation of the narrower QRS from a control of 0.8 to .12 seconds, (2) variation of coupling of the grossly aberrant beats to the preceding normal complex from .32 to .44 seconds and (3) lack of compensatory pause after the aberrant conduction ceases. The appearance of marked aberration is not surprising in view of the rapid rate and the known depressing effects of quinidine on excitation (QRS) and recovery (Q-T).

Figure 9. A 74-year-old man was admitted for

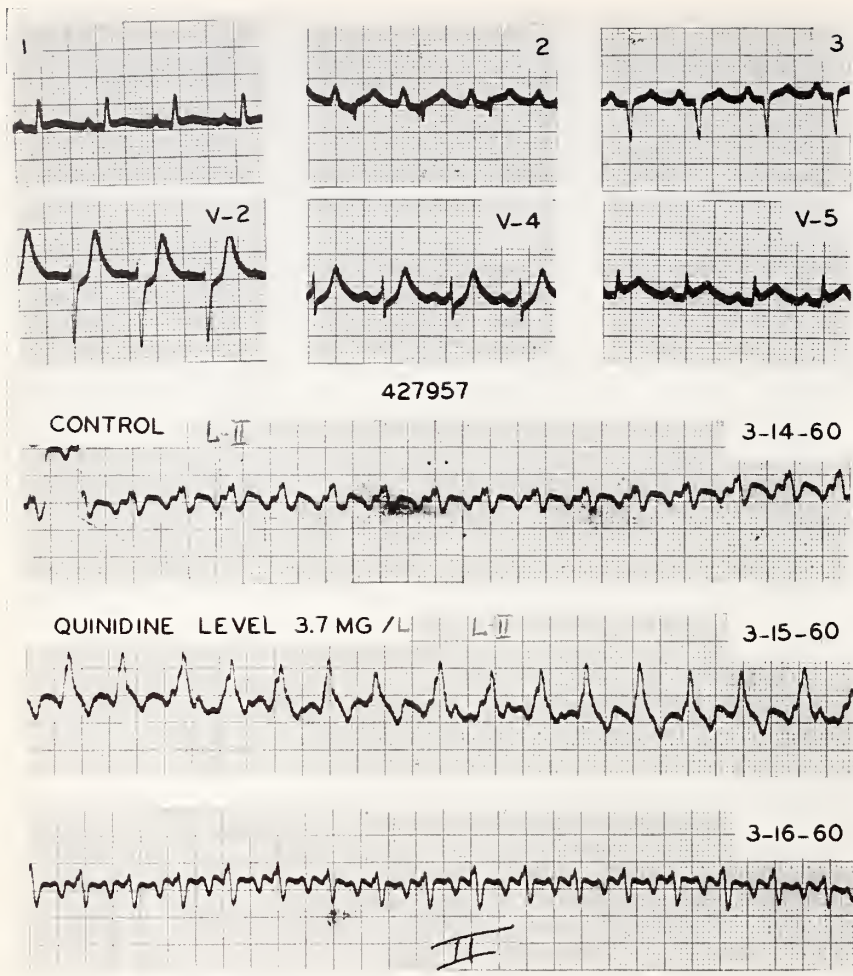


FIGURE 7

ACUTE MYOCARDIAL INFARCTION complicated by subsequent intraventricular conduction defect and atrial flutter. An attempt at conversion with quinidine caused further undering of the ventricular complex (3-15-60). For details see text.

treatment of repeated synocopal episodes complicating arteriosclerotic heart disease. The syncope was thought to be due to rapid ventricular rates associated with atrial tachycardia with varying degree of heart block (11-26-56). An attempt was made to convert the rhythm to sinus using "long acting" or "slow release" quinidine. Quinidine levels are noted on the ordinate and the amount administered on the abscissa. On the second day of therapy and at the time the level reached 10 mg per liter, there was a marked prolongation of the QRS complex (11-27-56). Quinidine was continued for two more days with the level varying from 6 to 10 mg per liter. The drug was discontinued at 8:00 p.m. on 11-29-60. A peak level however, of over 14 mg per liter, was not reached until 18 hours later with the EKG showing further widening of the QRS.

With ordinary quinidine preparation, the peak level is usually reached within two hours after the last dose and, as observed by Sokolow, "The blood level was invariably lower four hours after a given dose than at the peak two-hour level, the decrement usually being in the neighborhood of 10 to 20%, . . ." This, however, was not the case in this instance.

Summary

Salient features of quinidine therapy are reviewed and cases illustrating some of the undesirable side effects are presented.

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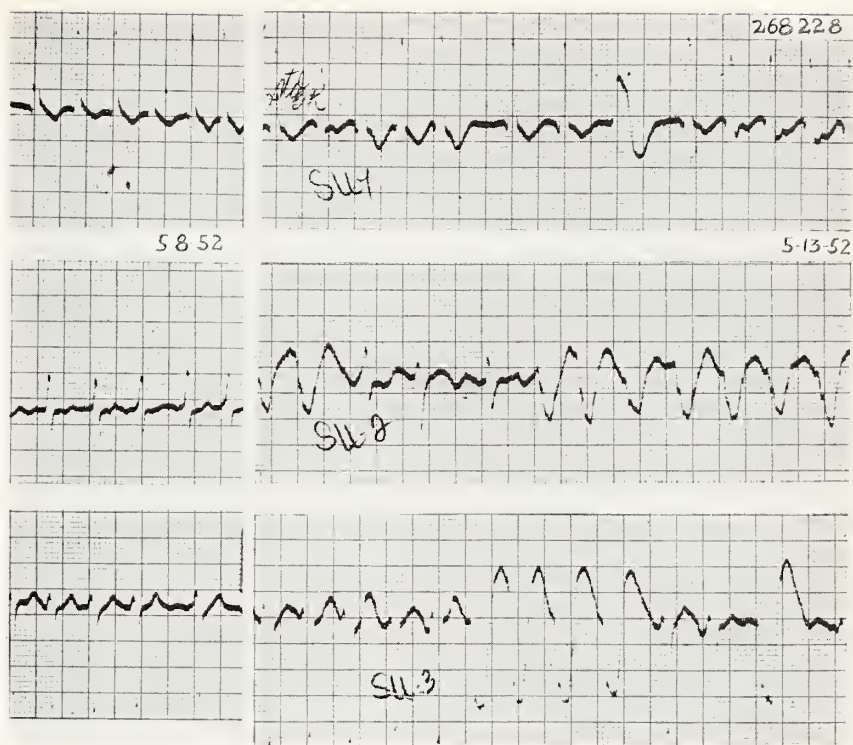


FIGURE 8

ABBERANT VENTRICULAR conduction due to quinidine which simulates ventricular tachycardia. For details see text.

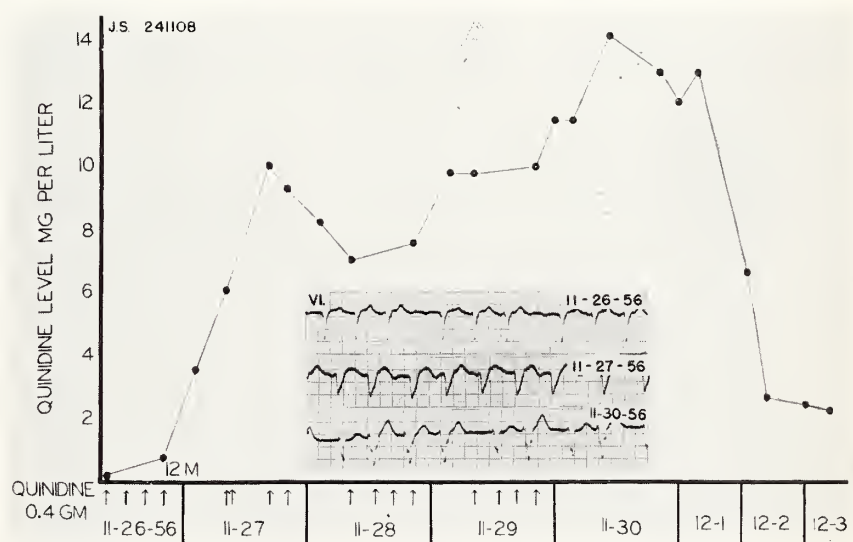


FIGURE 9

MARKED PROLONGATION of the QRS and the unpredictable response of blood levels to "slow release" quinidine preparation. For details see text.

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ADDENDUM

Subtitles inserted by the *Journal* editorial staff.

Diagnosis is difficult—but
not always impossible.

Myocardial Infarction in the Presence of Left Bundle Branch Block

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BUNDLE BRANCH BLOCK and myocardial infarction are rather frequently associated. Master¹ stated that approximately 15% of myocardial infarctions have this association. Both conditions are prone to develop in diseased hearts, and an infarction involving the septum may produce bundle branch block.

It is generally agreed that right bundle branch block offers no particular difficulty in the electrocardiographic diagnosis of myocardial infarction. The usual findings of infarction are not distorted by the right bundle branch block, inasmuch as the initial .04 sec. of the QRS is not disturbed. However, the presence of left bundle branch block is another matter. Since the septum normally depolarizes from left to right, the block in the left bundle changes the pattern of depolarization from the normal left to right, to the abnormal right to left. The initial .04 sec. of the QRS is thus distorted by the electrical positivity of the left ventricular cavity. The Q waves of infarction can therefore not be recorded. Wilson, in 1945, emphasized the great difficulty in making this diagnosis with certainty. Master¹ pointed out that the mortality rate of acute infarctions complicated by left bundle branch block

is twice as great as infarctions with normal IV conduction.

Through the years various approaches have been made to this problem. The difficulties are obvious in collecting a large control series of cases of left bundle branch block without myocardial infarction and a contrasting series with infarction. Each case should be proved by post-mortem examination or by previous EKG showing infarct with normal IV conduction. One difficulty has been not knowing all the possible variations that uncomplicated left bundle branch block may present in the electrocardiogram. Before certain changes can be associated with infarction, one should be certain that these changes are not "normal" variants of the left bundle branch block. At the present time this information is not known, and the associations are often uncertain.

Laboratory Approach

Kennamer and Prinzmetal² approached the problem from the laboratory standpoint. They produced left bundle branch block experimentally in dogs and then tied off a major coronary artery. The electrocardiogram was recorded by direct epicardial leads. They showed that in uncomplicated left bundle branch block the ST segment and T wave usually move in a direction opposite to the major QRS deflection. Also that with acute ischemia the ST segment becomes elevated in the direct left ventricular leads, replacing the "normal" depression. They thus showed that the changes which occur with acute

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injury (ST segment elevation) are the same with left bundle branch block as with normal IV conduction. Similar EKG findings were demonstrated in humans. They also showed that ST changes that occur during an exercise test or during angina are the same whether or not left bundle branch block is present. It should be emphasized that these ST changes may be subtle and not detected unless pre-infarction tracings are available for comparison. There is thus some experimental justification for hoping that myocardial infarction might produce changes in the electrocardiogram distinct from those of the left bundle branch block.

Somerville and Wood³ believed that of their 33 cases of left bundle branch block with a clinical history of infarction, 16 showed electrocardiographic abnormalities of myocardial infarction.

One of the most optimistic reports in the literature is that of Chapman and Pearce.⁴ They state: "Our review of 50 cases of myocardial infarction with left bundle branch block leads us to believe that a myocardial infarction produces changes in the electrocardiogram almost as often in the presence of left bundle branch block as it does with normal IV conduction."

Infarction Indicated by QRS Changes

They further state that in most instances the presence of the infarction is indicated by changes in the QRS complex, which are not always the same as those changes occurring during normal IV conduction. The study consisted of 30 cases of left bundle branch block with infarction, 13 cases without infarction, and a review of 20 cases in the prior literature. These cases were proved by autopsy, a previous EKG showing the infarct with normal conduction or an EKG with intermittent left bundle branch block. These authors felt there was a high correlation between antero-septal infarction and QRS abnormalities. Of more than 40 antero-septal infarctions the vast majority showed one or more of the following:

1. Q wave in I, AVL, or V6.
2. rsR' in I, AVL, or V6.
3. Abnormal progression of R wave across the precordial leads from right to left.

However, it should be noted that of the 13 control cases without infarction, five showed one or more of the above changes. In three there was "gross patchy fibrosis," in one there was a subendocardial infarction, and in the last there

was neither infarction nor fibrosis. No confident correlation was made between posterior infarctions and QRS changes. All three cases of acute infarction showed marked ST segment elevation. No correlation could be made with T wave changes, for as Sodeman⁵ showed, diphasic or upright T waves are not necessarily abnormal in the left ventricular leads in left bundle branch block.

In this series infarction involving the septum was almost seven times more common than infarction of the free wall of the left ventricle without septal involvement. It is for this reason that Q waves may appear in leads I, AVL or V6. The negativity of the right ventricular cavity is transmitted through the electrically dead septum and recorded as Q waves in these leads. It should be pointed out, however, that such Q waves do not necessarily mean infarction.⁶

Recently two investigators from Chile, Bessoin-Santander and Gómez-Ebensperguer, have published their findings in 127 patients with left bundle branch block.⁷ Of these patients 87 were controls with neither angina nor clinical history of infarction. (Twenty of these controls were shown to be free of myocardial infarction by postmortem examination.) Twenty-seven patients had angina. Thirteen patients had myocardial infarction with left bundle branch block, six of whom were proven at autopsy and seven showed either progressive EKG changes or the pattern of infarction prior to the development of the block.

Infarction Evidence in RS Complex

Unlike Chapman and Pearce these authors felt that the only reliable QRS evidence of infarction is an RS complex with broad R and broad S waves over the left precordium in more than one lead. Such a pattern in just one lead could indicate a transition zone. Of their 13 patients with infarction, three had such a pattern. None of the controls showed this pattern. They denied that Q waves or rsR' complexes (which are Q equivalents) have diagnostic significance. Of the 40 patients with Q waves, only eight had an infarction. A Q wave in lead I was found in 10% of their controls, and a Q wave in AVL was found in 25% of the controls. They also denied the importance of lowering or disappearance of the R wave in the precordial leads going from right to left.

With regard to the ST segment changes of infarction, these investigators were able to make

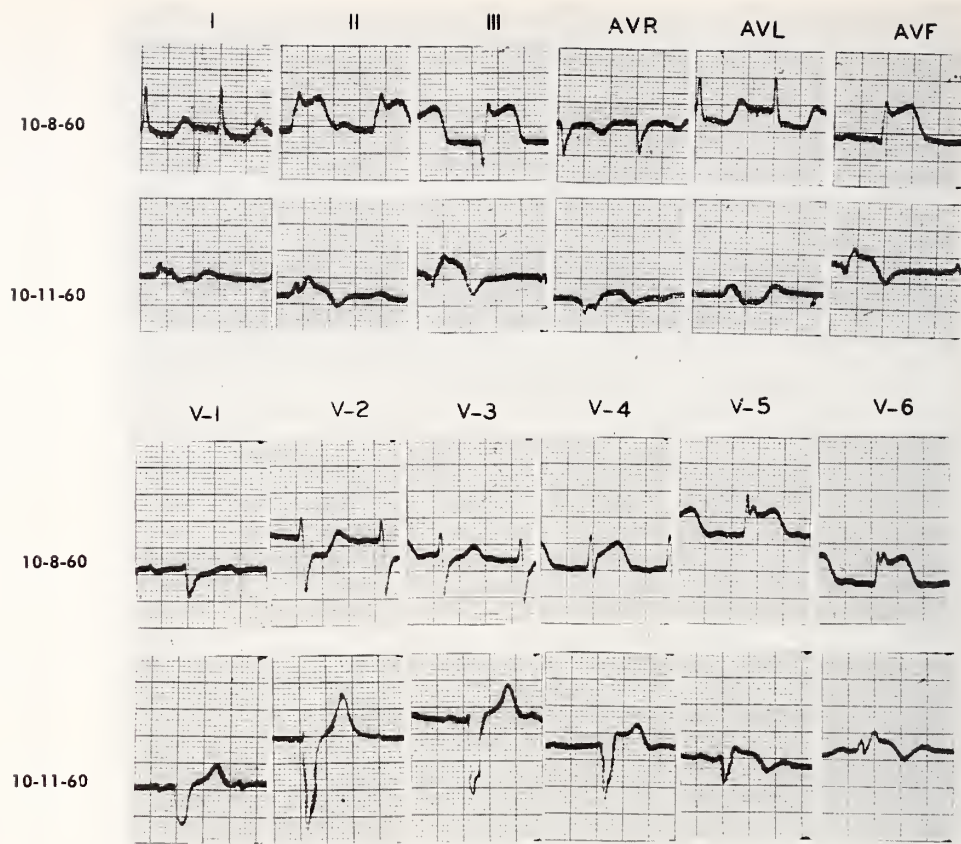


FIGURE 1

82-YEAR-OLD woman who had acute onset of severe substernal chest pain on 10-8-60. EKG showed first degree AV block and acute posterolateral myocardial infarction with marked ST segment elevation in II, III, AVF, and V4-V6. QRS is 0.08 sec. Three days later on 10-11-60 the QRS complex is .14 sec., and the pattern of left bundle branch block has developed. She died the same day. These tracings represent acute posterolateral infarction before and after the development of left bundle branch block.

several conclusions. Normally with left bundle branch block in the standard and unipolar limb leads, the ST segment is displaced in the direction opposite to that of the major QRS deflection. If the ST segment is displaced toward the major QRS deflection this would imply a current of injury and, thus, a recent infarction. They found this abnormality in two of their patients, both of whom had an acute infarction.

Their second conclusion concerned leads V1 and V2. Normally in left bundle branch block in these leads there is a broad deep S followed by an elevated ST segment and upright T wave. They found that in the absence of digitalis, if the ST segment elevation was greater than 8 mm. or greater than one-half the height of the T wave, this indicated recent infarction. Of the 26 patients who showed these findings in V1 or V2, 17 were taking digitalis, and nine had an infarction.

As with Chapman and Pearce, these investigators had difficulty in attaching significance to T wave changes. As stated previously T waves can be upright or inverted in V5 or V6, with or without superimposed infarction. However, if the T waves are inverted in V1 or V2, this is a primary T wave change and tends to support the diagnosis of acute infarction.

Sodi-Pallares⁸ has stated: ". . . RS-T displacements over the right or left precordial leads constitute perhaps the most valuable sign for the recognition of recent infarction in the presence of left bundle branch block." He considers these significant displacements to be of the type previously described.

Dressler and associates⁹ studied 28 "controls" and 15 patients with infarction. They felt that a Q wave in lead I or the left precordial leads was very rare in uncomplicated left bundle branch block and suggested infarction, especially

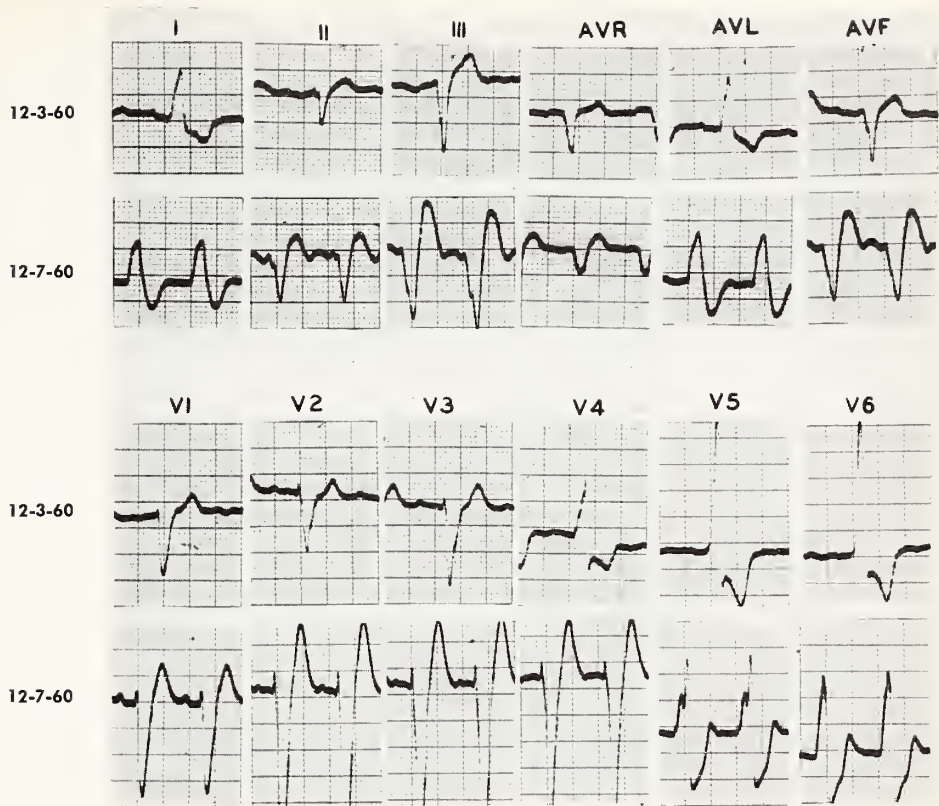


FIGURE 2

74-YEAR-OLD MAN admitted on 12-3-60 with chest pain and congestive heart failure. QRS duration was .12 sec. and could be considered either a diffuse IV conduction defect or left bundle branch block. On 12-7-60 the QRS widened to .15 sec., and the pattern was more clearly that of left bundle branch block. In addition, broad RS complexes developed in V5 and V6 (and V7). The patient died on 12-8-60. Autopsy showed a recent antero-septal infarction. In this case serial changes and broad RS complexes in V5 and V6 suggested the infarction.

with R waves in V1 and V2. They also described the ST-T changes of acute infarction.

Peri-Infarction Block Concept

Further complicating the problem of left bundle branch block and myocardial infarction is the concept of "peri-infarction block," first described by Bayley and elaborated by Grant and associates.¹⁰ They felt that up to one-third of the cases of so-called left bundle branch block are really peri-infarction block which closely mimic left bundle branch block. It is not within the scope of this paper to discuss peri-infarction block as such, but only its possible confusion with left bundle branch block. Grant believes that given an electrocardiogram resembling left bundle branch block, any of the following is strong evidence for peri-infarction block rather than left bundle branch block:

1. Q wave in leads I or V6 greater than .02 sec. He believes that infarction of the septum with left bundle branch block may cause such

Q waves, but that this is "exceedingly rare."

2. QS from V1 through V4.

3. Decrease in the R wave in the precordial leads going from right to left.

A Q wave in AVL is no help in differentiation. Grant states that the confident differentiation of the two conditions is often very difficult. However from the standpoint of patient management it would make little difference whether one was dealing with left bundle branch block with myocardial infarction or peri-infarction block masquerading as left bundle branch block.

Summary

1. The electrocardiographic diagnosis of myocardial infarction is difficult in the presence of left bundle branch block. However, in many cases such a diagnosis is possible, and a completely defeatist attitude is not justified.

2. The following EKG changes have been described as indicating myocardial infarction in the presence of left bundle branch block:

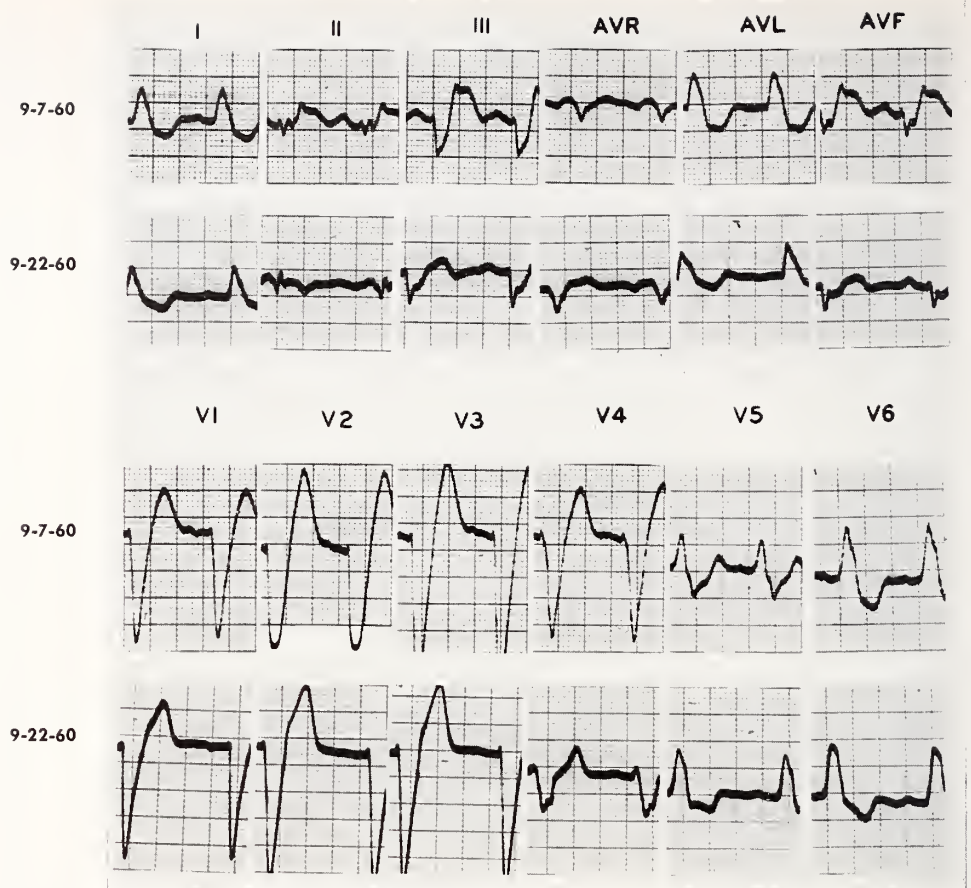


FIGURE 3

60-YEAR-OLD man who has had left bundle branch block since at least 1953. On 9-7-60 he had an episode of severe chest pain. An EKG showed the left bundle branch block with marked ST segment elevation in II, III, and AVF. Serum transaminase values rose to 130 and 165 units. Two weeks later, the ST segments returned toward the baseline. The EKG then appeared almost identical to what it had been prior to the acute episode. The patient survived. This is believed to represent an acute posterior myocardial infarction in the presence of left bundle branch block.

A. QRS changes

1. RS complexes over the left precordium in more than one lead. This criterion appears to be highly reliable.
2. A Q wave of rsR' complex in lead I or V6. These criteria are suggestive, but apparently they are not highly reliable.
3. Abnormal progression of the R wave across the precordial leads. This criterion is suggestive, but apparently it is not highly reliable.

B. ST segment changes

1. ST segment displacement toward the major QRS deflection. This criterion appears to be highly reliable.
2. In leads V1 and V2, in the absence of digitalis, ST segment elevation more than 8 mm or more than one-half the

height of the T wave. This criterion appears to be highly reliable.

C. T wave changes

1. Inverted T waves in V1 and V2. This criterion could strongly suggest ischemia, depending upon the clinical situation.
3. Illustrative electrocardiograms are presented.

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Smoking and Exercise

In moderate exercise, smokers breathe about 10% faster than nonsmokers and even faster in strenuous exercise. But during rest, the smoker appears to breathe as easily, although his heart rate may be a bit faster. In tests, neither smokers nor nonsmokers demonstrated outward sign of heart or lung impairment after heavy exercise. Persons displaying outward effects under similar tests might be suspected of having cardiac or pulmonary problems.—Dr. Henry E. Swann, Jr., U. of Pittsburgh, *G.P.*, Oct. 1960. (American Physiological Society, Palo Alto, Calif., Aug. 26.)

The Case of the Sterile Siren



ARNOLD LIEBERMAN, M.D.*
New York, N. Y.

FIRST, IT WAS THE HUSBAND who came to our office. He was a famous international playboy whose highjinks had provided much material for the gossip columns of the press; currently, he was in the limelight more as the recently acquired husband of the famous screen beauty whose slinky, sultry stride was proclaimed the very acme of sexual allure. Her siren pin-up pictures decorated magazine covers, *Esquire* calendars and G.I. barrack walls.

He did not belie his reputation of being the typical male eternally on the prowl. He was a fashion plate: every crinkle and crease of his super elegant, dernier cri clothes was just so; every virile hair on his scalp was on the precise side of the part; the waxed mustaches would not have shamed Adolphe Menjou. There was a suspicion of some eye-shade around the lids, the face had been freshly shaved and carefully powdered. The nose was rather fleshy with flaring nostrils and the facial expression was earthy rather than intellectual; there was a hint of a beginning rotundity in the girth that was testi-

mony of his devotion to the fleshpots. He was a chunky five and a half feet, 175 lbs. of Latin masculinity.

Prosaic Tomcat

Unfortunately, as the conversation opened, the leopard became a very prosaic back alley tomcat. In brief, his capacities had been challenged: he had a very earthy determination to reassert beyond the shadow of peradventure his ability to become a father. He had been married to the actress for over a year. "I teach her amour every night," he reiterated emphatically, making an indescribable, vividly eloquent gesture. "She knows noddings but she learn: And still: NO BABIES! She wanta know why; so, I go to doctor to prove I'm O.K."

As I am internist, I could not refrain from, "Why did you come to me of all people?" "Vell: You treat my friend for his heart; everybody say he die, you get him vell; I come to you!"

Even intelligent people select (quite often) their physicians for the weirdest of reasons; in this instance, a comment would have been superfluous: we proceeded to the usual physical examination; the obvious laboratory studies indicated were simple and executed with ease.

The man had a superb physique; the I.Q. may not have been excessive but the sperm count was

* One of a series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind.

certainly superabundant: the slide swarmed with actively motile, perfectly formed male elements. The reproductive system was flawless—an enviable mechanism. The honor of this darling of café society having been so fully vindicated, he clicked his heels, twirled his mustaches and left trailing a strong, exotic perfume as he stalked through the exit, the cynosure of admiring female glances.

The little episode was dismissed as an amusing interlude and was a cause for office comment for only a day or two. Imagine my surprise when my secretary informed me that the screen star wife of our Lothario had called and insisted on making an appointment for herself. Furthermore, contrary to her widely publicized habit of being late, she was in the waiting room at the exact time given to her. Off stage and minus her props, she proved a surprisingly pleasant, charming young woman. The more I listened to her story, the more incongruous became the knowledge of her deliberately choosing the husband she had.

The details of the history and examination cannot be TOO specific as the actual figures and such things are too well-known generally even now. The problem gnawing her at the present was the fact of her apparent inability to become a mother. She had been reared in a very religious family; her mother's devotions attempted to compensate for an alcoholic, dissolute father. She had had a very searing childhood: one of a large brood, she had had to fend for herself since her earliest teens. Her mother had little time for the beautiful daughter because of the pressing problems of just feeding the children; at the bottom of the depression they were on relief; she had known the literal meaning of hunger.

Left School to Clerk

She had had to leave grammar school and go clerking at Woolworth's—the \$10.00 weekly meant so much then. Almost as a compensation, the mother had incessantly drummed into her children devotion to the Church, the Ten Commandments, family duties and social obligations. Her mother had “gone into a decline” and died in a sanatorium; she had had to assume responsibilities for the family before she was 20. Her photo had been entered in a magazine contest; it won a prize. The attention of a casting director came her way; she was given a tiny role; she had the certain “something.” Hollywood was soon making her a world sensation.

Her first marriage produced no children; after her first husband's tragic death, she re-married. He went to war and never returned. Some time later, the desire for children and family became an obsession with her; that is how she came to be psychoanalyzed; that was also the reason for the present union. Still, there were no children and she was already past 30. Her husband had been loud in the praises of his examination; that is how she came to me.

“Madam, have you had any real physical examinations lately?”

“Oh, yes! Repeatedly!” She cited some rather well known names. . . .

We went through the usual examination plus some gynecological refinements. A careful bimanual revealed the interesting fact that both oviducts were not only palpable but much harder than usual; they were freely movable but of almost pipe-stem brittleness. There was no trace of a cervical discharge and both ovaries felt completely normal.

My gynecological colleague did a Rubin patency test: air did NOT go through. The Mantoux test was definitely positive even if the chest film was absolutely within normal limits. Neither gonorrhea nor syphilis could be the etiological agents here. She was *sterile*, however, through no fault of her own and HOW WAS I TO BREAK THE NEWS TO HER? To tell her bluntly that she was barred from motherhood could drive her even to suicide or worse. . . .

First, I discussed the situation with my surgical friend: I broached the thought of having him do a laparotomy, dissect the tubes open and insert polyethylene tubes to maintain patency. He rather shied at the thought. “The procedure is strictly experimental; it has worked for me in dogs and rabbits, it is true, but I've done it only in two humans; how do we *really* know it is genital tuberculosis? For all we can tell now, it might be just old fashioned g.c. pus tubes. How can I guarantee her anything? That would be charlatanism of the worse sort.”

Of course, he was right. We might also be lighting up a quiescent tuberculous process and iatrogenically getting her into REAL trouble. Still, I thought we could lay the matter before our patient and give her hope—the priceless ingredient. So, with the surgeon present, we had a long consultation with our famous patient. We explored the matter with her, suggesting that she probably had acquired tuberculosis of her



Mirabile dictu—
She was pregnant

private hospital under a pseudonym. I acted as the surgeon's second assistant (I hope the Board of Internal Medicine will overlook this). The pathology was minimal; the frozen section did show the tuberculous granulomas. The surgeon did a brilliant plastic restoration according to the technic now well described and known. The patient convalesced without a hitch and did leave on a round-the-world cruise.

Six months later she visited our office; *mirabile dictu*, she *was* PREGNANT!!! In due time, the obstetrician delivered her uneventfully.

Then two more children were born to our star. If anything, motherhood has enhanced the subtle "something" that still makes her the very epitome of sultry sex. Her studio still bills her as the slinky siren beckoning the bemused male.

Her husband, quite obviously, is still around. To quote a columnist, "while Washington is full of famous men and the women they married when young, Hollywood is full of famous women and the men they married when young!"

My surgical colleague says that I am just prejudiced against the man; the lady psychiatrist looks at me rather pityingly and says that I just don't comprehend the feminine viewpoint. Frankly, the now fertile siren and her vast audience are happy and that is all that matters. ◀

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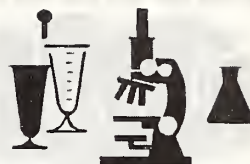
Fallopian tubes at the time when her mother had had to go into the sanatorium and she herself had been "sickly" at the time of her menarche. We pointed out that the sister who had been so ill at the same time might very well have had T.B. also.

Look-see Operation

We suggested the exploratory laparotomy with the thought that IF our diagnosis was correct the situation MIGHT be corrected; of course, nothing could be guaranteed but at least she would know, one way or the other. After long reflection, she did decide to have the "look-see" operation.

Her studio gave out the tale that she was going on a cruise for a rest; she entered a small





What's New in Hematology?

IN RECENT YEARS the frontiers of hematology have expanded in various directions. Here are a few important aspects:

Anatomy, Physiology and Biochemistry

With applications of modern electron microscopy, x-ray scattering technics and biochemical procedures, much detail in the cellular structures and metabolic pathways has been learned. Many cellular enzymes have been identified and some of them are now well understood. In the investigation of drug-induced hemolytic anemias, the drug-sensitive red cells have been found to be deficient of certain enzymes, especially glucose-6-phosphate dehydrogenase. The enzymatic deficiency results in a decrease in reduced glutathione which may be detected by the *in vitro* glutathione stability test. The precise defect in hereditary spherocytosis has been suggested to be due to a block at the phosphofructokinase step in the cellular metabolic processes and there may be more than one type of metabolic defect associated with the structural abnormality. Other investigations on enzyme systems have revealed defective methemoglobin reductase in methemoglobinemia and defective phosphogalactose transferase in congenital galactosemia. Leukocytes in leukemia generally show deficiency in enzymes for aerobic glycolysis.

Two humoral erythropoietic factors have been described, one being a relatively thermolabile factor and the other being a thermostable ether-soluble factor. The role of various erythropoietic factors in physiologic and pathophysiologic control of erythropoiesis has been much elucidated. Hypoxia, as measured by tissue oxygen tension, has long been recognized as an important erythropoietic factor and probably regulates both humoral factors. Anemia usually results in hypoxia which in turn accelerates the erythropoiesis. Adrenal steroids in therapeutic dosage

may stimulate erythropoiesis in a slightly different manner, probably through increased oxygen requirement of the bone marrow.

Histochemistry

Advances in histochemistry have made it feasible to demonstrate the various enzymes and chemicals in the blood cells. The mature neutrophils in chronic myelocytic leukemia usually show decreased activity in alkaline phosphatase, while those in chronic lymphocytic leukemia and acute leukemia show increased activity of the same enzyme. The lymphocytes in lymphosarcoma and chronic lymphocytic leukemia usually show increase in glycogen, mucopolysaccharides, desoxypentose nucleic acid, dehydrogenase and phosphorylase.

Hemoglobins and Hemoglobinopathies

More than 20 different types of hemoglobin have been discovered and many syndromes due to the presence of abnormal hemoglobin or a combination of hemoglobins have been described. These hemoglobins are different in regard to the nature or structure of their globin portions. They are differentiated from one another by means of electrophoresis, alkali denaturation, chromatography, solubility, ultraviolet spectrum and immunologic technics. A detailed review on the subject has been previously presented (*J. Ind. State Med. Assoc.*, 52:2143, 1959). Most, if not all, of the abnormal hemoglobins are related to genetic anomalies.

Blood Group Factors and Immuno-hematology

At least 56 blood group factors have been discovered and the nature of many blood group substances has been clarified. The importance of terminal sugar moieties in the determination of antigenic specificity of the blood group sub-

stances has been confirmed. The discovery of $R^{ox}(-D-)$ gene has brought a new exclusion rule in interpretation of parentage based on factors $rh'(C)$, $hr'(c)$, $rh''(E)$ and $hr''(e)$. There has been an increasing number of transfusion reactions due to leukoagglutinins and antibodies against rare blood group factors. In addition to Rh factor erythroblastosis fetalis has been observed in ABO incompatibilities and antibodies against other blood factors. Antibody demonstration by fluorescent methods or through the use of enzyme-treated cells represents another achievement in immunohematology.

Genetic Implications

Different kinds of genetic mutations affecting the various enzymes in red blood cells have been offered to explain certain hemolytic anemias. In addition to hereditary spherocytosis, methemoglobinemia and congenital galactosemia aforementioned, genetic implications in the form of enzymatic abnormalities have been suggested to explain elliptocytosis, leptocytosis, acanthocytosis, non-spherocytic hemolytic anemia and paroxysmal nocturnal hemoglobinuria. Effects of genes and their interaction on blood group substances have been repeatedly confirmed. Genetic phenomena have also been suggested to involve secondarily the red cells in pernicious anemia, familial hypoplastic anemia (in Fanconi's syndrome), familial hypochromic anemia, hemochromatosis and porphyria hepatica. Similar genetic mutations may be expected to affect the enzymes in cellular elements other than red cells in the circulation.

Extensive work has been done to explain the genetic implications in hemoglobinopathies. The globin portion of each hemoglobin molecule is subjected to chemical, electrophoretic and chromatographic analyses for its component chains and the end group of each component chain in terms of amino acids arrangements. The principal part of the procedure is commonly known as finger printing study which reveals the peptide pattern—the peptide linkage and the specific arrangement of the amino acids in each peptide chain. Any genetic mutation could be revealed in the formation of the peptide chains and linkage which in turn control the inheritance of hemoglobin. Genetic consideration in hemoglobinopathies has also been studied by means of dissociation and recombination.

Blood Coagulation Factors

New coagulation factors have been discovered and the mechanism of coagulation has been made unnecessarily complex. In the first stage of coagulation Hageman factor, platelets, plasma thromboplastin component (P.T.C.), plasma thromboplastin antecedent (P.T.A.), antihemophilic globulin (A.H.G.) and Stuart factor in the presence of factor V (labile factor, proaccelerin) and calcium react to form plasma thromboplastin. In the second stage plasma thromboplastin, factor V, factor VII (stable factor, proconvertin) and calcium all react with prothrombin to form thrombin. In the third stage thrombin reacts with fibrinogen to form fibrin clot. Various hemorrhagic disorders due to deficiency of the coagulation factors have been reported. Some of the disorders are congenital and others acquired. Many anticoagulation substances naturally occurring or occurring only in pathologic states have been confirmed. A number of laboratory tests have been designed to study the coagulation factors and the anti-coagulation substances.

Chemotherapy of Leukemias and Lymphomas

It is estimated that approximately 50,000 compounds for possible therapeutic use in leukemias and lymphomas are screened each year by 17 principal groups of investigators in this country. Only a limited number of them have been found to be applicable to humans. Valuable alkylating agents include nitrogen mustards, triethylene melamine (TEM), chlorambucil (Leukeran), busulfan (Myleran), cyclophosphamide (Cytosan) and epoxypipidine. As a group the alkylating agents have been found to be effective in the treatment of lymphomas, especially Hodgkin's disease, chronic leukemias and selected cases of acute leukemias and carcinomas. Cyclophosphamide and epoxypipidine are relatively new agents and are less toxic than the others. Cyclophosphamide is particularly useful in the treatment of lymphosarcoma. Epoxypipidine has been evaluated at the Indiana University Medical Center and appears to be useful in the treatment of lymphomas and probably chronic leukemias.

Another group of chemotherapeutic agents is called antimetabolites. These include folic acid antagonists, purine antagonists, glutamine antagonists and fluorinated pyrimidines. As a group

the antimetabolites have proved most effective in the treatment of acute leukemias.

A third group of drugs includes adrenal steroids and their synthetic derivatives. These are most useful in the management of acute lymphoblastic leukemia, acquired hemolytic anemias and certain hemorrhagic disorders.

The last group of agents includes actinomycins for certain lymphomas, urethane for multiple myeloma and vincalukoblastine (VLB) which represents another new drug currently under investigation at the Indiana University Medical Center. Vincalukoblastine is an alkaloid extracted from periwinkle plant and has been found to be effective in the treatment of cutaneous Hodgkin's disease, acute leukemias, adenocarcinoma of colon and reticulum cell sarcoma.

Marrow Transplantation

Marrow transplantations have been performed in large numbers of animals and to a lesser extent in humans. Human cases including acute leukemias and marrow failures are generally limited to isologous and homologous transplantations

because of immunological problems. In acute leukemias the patient is generally given a large dose of whole body irradiation prior to marrow transplantations. Results have not been entirely satisfactory and are not yet justified for a final conclusion. However, marrow transplantation does open a new approach in the management of drug-fast acute leukemias, marrow failures and radiation injuries.

Application of Radioisotopes

Radioisotopes are becoming more and more important in all phases of hematology including research, diagnosis and therapy. Many of the new achievements in the aforementioned paragraphs were made through the contributions of the radioisotopes. The uses of various radioisotopes were discussed in a previous writing. (J. Ind. State Med. Assoc., 53:2209, 1960). ◀

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Medicine Offers Maximum Promise to Today's Student

Since 1956 the number of students applying for admission to the nation's 85 medical schools has dropped from 15,917 to 14,951. In 1947 nearly seven percent of all college graduates made applications to medical schools, while in 1958 the figure was only four percent. The low birth rates in the '30's as well as multiplying opportunities in other fields are thought to be contributory causes.

This decline in the number of applicants is occurring at a time when the rate of progress in the medical field is higher than ever. In 1940 medical research activities cost \$45,000,000. This year it will reach roughly \$600,000,000 and the predicted figure for 1970 is \$3,000,000,000.

Nine new medical schools have been created since the end of World War II. Other encouraging factors are an attempt to combine college and medical school into a single program, thus enabling a student to obtain his M.D. in six or seven years, and the increase in financial resources now available to the medical student.—
J.A.M.A., Oct. 29, 1960

LABORATORY MEDICINE

Published periodically as a review
of clinical laboratory procedure
suitable for laboratories with minimal equipment.

Lignin Test for Sulfonamides

A. WENDELL MUSSER, M.D.*
Indianapolis

MODERN MEDICINE has brought to us in recent years many new and wonderful modes of therapy. One of the greatest of these was the advent of sulfonamides and antibiotics. Although new antibiotics are introduced almost on a daily basis, sulfonamides are still quite useful and safe if proper fluid intake and minimal alkalinization of the urine is assured. Sulfonamides can be dangerous and occasionally an individual is encountered who is sensitive to even the smallest dose. Therefore, a screening test to detect the presence of sulfonamides in the urine would be of benefit in following patients to whom sulfonamides have been administered.

Soluble sulfonamides are readily absorbed from the intestine, appear in the blood and other body fluids and are excreted by the kidneys. A portion of the circulating sulfonamide undergoes acetylation of the amino group attached to the benzene ring and becomes therapeutically inactive. This coupling appears to take place in the liver. Both the free and acetylated forms of the sulfonamides are excreted by the kidney.

Runge has shown that salts of aniline produce an intense yellow color on fir wood when hydrochloric acid is added to the solution. Other authors have shown that this property was not restricted to fir wood but that any kind of

wood exhibited the same color reaction when brought into contact with the reagents. The sulfonamides are aniline derivatives and accordingly they have proved to react in the same way with wood fiber like the other aniline derivatives. Paper produced from wood pulp gives the same reaction, while that produced from rag wastes give no reaction. Therefore, it could be concluded that like other aniline derivatives, sulfonamides reacted with the lignin of wood to produce a yellow color. The following screening test for sulfonamides was thereby proposed.

Method

To newsprint paper or strips of lignin paper add two drops of urine. Add two drops of 10% hydrochloric acid. A deep canary yellow color appears in the presence of sulfonamides.

This test will be positive in specimens where the sulfonamide concentration is 1:10,000. It may be applied to spinal fluid or other body fluids. This test should be used to verify so-called sulfa crystals since crystals are not always the same shape and size. It is positive where no crystals are present.

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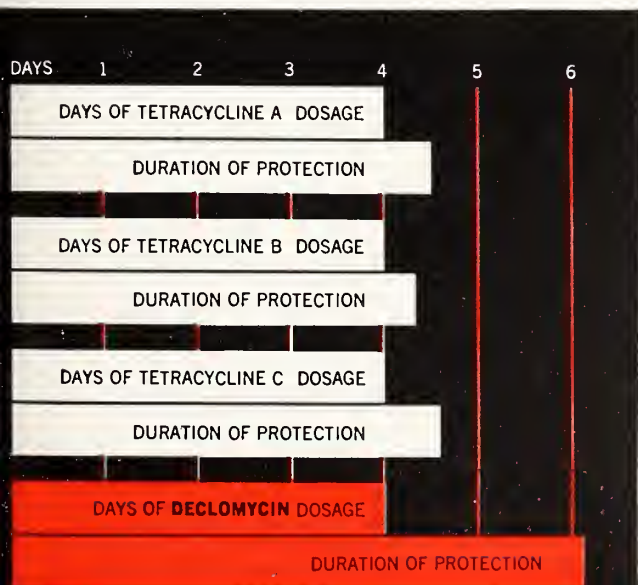
*From the Clinical Laboratory, Indiana University Medical Center.

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Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.



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Cardiac Arrest

RESUSCITATION OF PATIENTS by open thoracotomy and cardiac massage was originally an emergency procedure carried out in the operating room when cardiac function was suddenly arrested during a surgical operation. The procedure is now standardized and has been performed successfully in enough instances to warrant its application to almost any patient with sudden heart stoppage if the accident happens in the operating room.

Most surgeries are now equipped for such an emergency thoracotomy and surgeons and operating room personnel are trained sufficiently to facilitate a prompt resuscitation.

Success of the maneuver depends on the institution of cardiac massage and the ventilation of the lungs with oxygen within a period of a few minutes after the heart has stopped. If the interval is too long the patient dies of central nervous system damage due to anoxia of the vital centers, or he survives with loss of important cerebral functions. Only those patients in whom it is possible to restore some peripheral blood flow and for whom it is possible to insufflate the lungs with oxygen within a few minutes will survive with cerebral function.

Since cardiac arrest is not limited to patients

in the operating room, it is inevitable that the procedure would be applied to cases of heart stoppage occurring in other parts of the hospital. When applied with dispatch by trained personnel using adequate equipment the salvage rate on these so called "medical arrests" has been encouraging. A few successful cases have been reported in which the patient suffered cardiac arrest due to ventricular fibrillation as a complication of coronary occlusion.

Dr. George Holswade¹ and his associates at the New York Hospital reported two cases of successful resuscitation for patients who suffered cardiac arrest in the hospital, but outside the operating room.

In discussing the cases the authors emphasize the necessity of having the proper personnel and equipment immediately at hand. They do not deny the possibility of successful resuscitations outside the hospital, but feel that such dramatic emergency procedures should not be attempted unless the proper equipment is at hand.

They list the following factors to be considered in all cases of acute heart stoppage:

1. *Type of patient*—Resuscitation should be attempted only when cardiac arrest has been sudden and unexpected. "This would eliminate

patients with incurable disorders and those in whom death is the next step in the progress of their disease."

2. *Location of patient*—Resuscitation attempts need not be confined to hospitals, but they require such essential equipment as oxygen, heart stimulants and drugs, electrical defibrillators and material for closing the chest within 20 minutes.

3. *Personnel*—At least two people are necessary: one to open the chest and massage the heart, the other to provide mouth-to-mouth respiration. If lengthy massage is required, several people must take turns. A surgeon and anes-

thetist should be on 20-minute call to close the chest.

4. *Duration of cardiac arrest*—"When there is evidence that the patient has been apparently dead for at least 10 minutes, no attempt should be made to open the chest."

5. *Orderly sequence*—Resuscitation should not be started unless the doctor is reasonably sure all the procedures can be completed, in orderly sequence.

1. Holswade, George R., Bogen, Joseph E., Baldwin, John N., Goldsmith, Edward I.: Resuscitation from Sudden Death Due to Coronary Thrombosis, *Journal of the American Geriatrics Society*, December, 1960.

Award For Reducing Accidental Injury, Death

THE FIRST \$1,000 AWARD of the Metropolitan Insurance Company was made this year for "the most significant contribution toward reducing the toll of accidental injury and death."

The award was established to encourage investigators in the field of safety, and to induce researchers in other fields to include in their studies the problem of accident prevention.

Accidental injury and death is one of the biggest health problems. Over 90,000 deaths occur annually in the United States by accidental means. More than 100 times this many people are injured badly enough to necessitate at least one day away from work. In 1959 the Metropolitan alone paid a little more than \$50 million in death claims on policyholders killed in accidents; more than half of this amount was for motor vehicle deaths.

The first award went to Dr. B. J. Campbell, Assistant to the Director, Automotive Crash Injury Research, Cornell University.

Dr. Campbell devised a point system as a method of selecting drivers in need of improvement. Points were charged for each traffic violation. When a certain number of points were accumulated some type of disciplinary action

was taken. It was found that the number of non-accident violations was directly proportional to the number of accidents for each driver. Those with no non-accident violations averaged .167 accidents. Those with one non-accident violation averaged .391 accidents, and those with two had .560, those with three had .699, and those with four had .857, while those with five non-accident violations had 1.001 accidents on the average.

The payoff was that the point system with corrective action improved drivers' records. In New Jersey a study of 14,000 drivers showed that those who were subjected to action in accordance to the point system increased the average interval between violations. Moreover the violations subsequent to disciplinary action were less serious than those committed earlier.

The Metropolitan Life Insurance Company in its Statistical Bulletin makes the point that accidental injury is one of the major causes of death for which the responsible factors may be determined more easily than is the case with such diseases as cancer and cardiovascular abnormalities. However, research is required. The Metropolitan award is designed to encourage that research.

'Vitamania'

DR. E. VINCENT ASKEY, President of the AMA, has described a new disease. Obvious symptoms are practically identical to those of hypochondriasis. The disease is characterized nationally by the compulsive spending of millions of dollars for self-prescribed medication which

usually accomplishes no good and sometimes results in harm. Name of the disease — "Vitamania."

Some of the vitamins sold on a non-prescription basis are correctly labeled, some are not. Some vitamins are promoted without false pro-

motional claims. Some are promoted with outlandish claims.

Recently the Food and Drug Administration seized over \$12,000 worth of a vitamin-mineral preparation together with over three million pieces of labeling literature said to contain false and misleading claims. The charge was based on labeling claims for the treatment of 32 physical and mental conditions, including depression, tension, impotence, growth failure in children, lowered resistance to disease, aging and lowered vitality.

Full page newspaper advertisements have appeared in Indiana, ironically headlined "The Truth About Vitamins" and beginning with "Today, most authorities agree that the average person requires more vitamins and minerals than he receives in the usual well-balanced diet."

With such unsupported statements as this in print, with television and radio advertising along the same line, it is not hard to understand why

the public is bunkoed into spending its hard-earned money for medicine which helps only the people who make and sell it.

Dr. Austin Smith, President of the Pharmaceutical Manufacturers Association, has described a "growing quasi-medical underworld which grosses each year from its victims a sum equal to one-third to one-half the annual sales of ethical drugs by legitimate manufacturers."

Many medical organizations are joining the AMA this year in an organized nationwide effort to educate the public on "nutritional quackery, fake arthritis remedies and medical bunkoism." Cost of self-prescribed patent medicines and patent gadgets is astronomical. The public could get the advantage of a 30 to 50% savings on its medical bills by following its doctors' advice and by avoiding all quackery. Reputable pharmacists would prefer to dispense the products of the reputable manufacturers.

Guest Editorial

Freedom of Choice

WE WISH TO EXPRESS our sympathy and extend our best wishes for a speedy recovery to Walter Reuther and Emil Mazey who are confined to hospitals.

Mr. Reuther, in addition to his job as President of the U.A.W., is president of the C.H.A., a union medical and hospital project organized by Mr. Reuther. Mr. Mazey, in addition to his job as Secretary-Treasurer of the U.A.W., is a director of the board of C.H.A. This board presently supplies a staff of doctors and operates the Metropolitan Hospital in Detroit to provide a closed panel type of medical care for the members of the U.A.W.

When the C.H.A. recently announced its extended plans of operation in competition with Michigan Hospital and Medical Service plans, doctors were concerned for the ethics of medical practice. It was feared that union management might adopt methods of coercion and compulsion which would destroy the finest qualities in present day medical care. When people are ill their total security is in the balance and they want treatment in which they have confidence. This

gracious propaganda about all medical service being the best goes out the window, and each man insists upon choosing that source of treatment which he really believes to be the best. We indorse without reservation the inherent and fundamental right of every man to make this choice. The control of medicine by lay boards is abhorrent to most physicians and has proven disastrous for the public.

It is, therefore, with considerable relief that we note that C.H.A. has no such coercive policy in regard to medical care, for both the President and a prominent Director have established their principle not only of free choice of physician, but also of free choice of hospital and medical care insurance coverage.

Mr. Reuther is in the Henry Ford Hospital for the treatment of a throat condition. Mr. Mazey is in the University Hospital at Ann Arbor for surgery on the kidney. Since Mr. Reuther and Mr. Mazey did not choose to use their own hospital or their own medical service, they cannot with honor deny this essential freedom to the members of their organizations. We

salute both these gentlemen for their observance and preservation of a great ethical and humanitarian principle in the practice of medicine.

—From the *Detroit News*, Sept. 23, 1960; by

D. W. McLean, M.D. Reprinted from the editorial page of the *Detroit Medical News*, Oct. 10, 1960, with permission of the author and of the editor.

Editorial Notes . . .

One-third of the families in the U. S. spend more than \$1000 per year for medical care. The group averages 38.9 physician visits per family per year, and accounts for three-fourths of the total medical care cost of the nation (\$12 billion of the total \$16.2 billion). As a group 49% of the medical care bill is covered by hospital and surgical insurance. Within the group the higher spending families have higher percentages covered by such insurance. The fact that 69% of the families spending in excess of \$1000 annually have at least one member who is under a physician's care for a chronic illness argues for the addition of insurance to cover physicians' services, according to Health Information Foundation.

The U. S. Atomic Energy Commission has awarded Consumers Union a \$20,000 research contract to help finance research on the presence of strontium-90 and seven other radioactive elements in daily diets in 25 cities. Most of the cost of the project will be born by Consumers Union which has been conducting studies of the level of strontium-90 in milk and in the total diet for several years. Representative meals will be prepared by home economists, packed in special containers and shipped to the laboratories for analysis.

A new journal, *The Journal of Surgical Research*, will make its appearance in May, 1961. It will be published by W. B. Saunders Company. It will carry no advertising and will specialize on publishing worthy articles with a minimum of delay. In accordance with this policy the size of issues will vary; the expected average is 64 pages. Dr. Charles G. Child, III, University of Michigan, is editor.

The Federal Food and Drug Administration has evidence that drug counterfeiting may be on the increase. Two recent seizures, one involving 3,500 counterfeit tablets of Serpasil, the other counterfeit Diuril and Hydrodiuril have prompted warnings to druggists to be alert for suspicious practices and to insist on sealed

manufacturers' packages. Some of the counterfeit drugs are transported in unlabeled paper bags and unlabeled bottles.

Since 1900 the average life expectancy in this country has risen 47%—47.3 years to 69.7 years. Females and males both increased their life span, but females who boasted greater expectancy in 1900 gained still more difference by 1959. Males gained 20.1 years and females gained 24.4 years which added to their two-year advantage in 1900 now places them 6.3 years ahead of the males. The white population has always lived longer, but since 1900 the difference according to race is lessening. While whites were gaining 22.7 years non-whites gained 30 years of expectancy. The difference between whites and non-whites in 1900 was 14.6 years, now it is only 7.3 years. (*Progress in Health Services*, Health Information Foundation, December 1960.)

Dr. Lowell T. Coggeshall, Vice-President of the University of Chicago, was honored as the recipient of the 1960 Honor Award of the American Medical Writers' Association at its annual meeting in Chicago on Nov. 19. The award was made for "distinguished contributions in writing, editing, publishing, and other means of communication in medicine."

The medical education campaign against quackery and patent medicine will be aided by a recent article on cold remedies in *Today's Health*. Written to acquaint the public with the facts, the article estimates that \$309 million are spent each year for package cold and cough medicine off the drugstore shelf. Since there is no known drug which will prevent or cure a cold, the only benefit to be derived from this type of medicine is symptomatic, and as the article states, most of this type of medicine doesn't do a good job of relieving symptoms. Almost any medicine, taken for several days, will cure a cold. Allowing the cold to get well by itself without medication takes no longer.

President's Page

RECRUITMENT — TOP PRIORITY

Few would have dreamed five or ten years ago, that many of our medical schools would now be concerned that qualified applicants for admission are on the decline.

A report in the *John Hopkins Magazine*, publication of the university, states that "to provide the doctors needed by 1975, the United States must expand existing medical school facilities and build 20 to 24 new medical schools."

The report estimates that, to keep up with the population growth American medical schools will have to increase their output of physicians from the present annual rate of 7400 to 11,000 by 1975. But at present the report points out, medical schools are expected to turn out only about 9000 physicians a year by 1975.


Furthermore, the report continues, applicants for admission to medical schools fell from 15,791 in 1957 to 14,951 last year, although college enrollments generally, were rising.

The problem is worsened, the report maintains, by the unyielding opposition of the American Medical Association to Federal aid to medical education. Unless the AMA modifies its opposition, it states, there is danger that Federal aid, since it is inevitable (sic) will come in less effective ways than if the association helped to work out the details.

The report sums up the problem as follows: "We need more doctors. To train them we need more medical schools. But we don't have qualified teachers to staff new schools, and the quantity and quality of medical applicants is declining. One reason for the decline in quantity is the time and expense required for a medical education. Efforts to reduce the time by trimming the curriculum are hampered by the fantastic rate at which we are accumulating new knowledge and the necessity for keeping the scientific emphasis on medical education."

From the statements above it is apparent that with present facilities expanded the rate of growth of medical graduates by 1975 will reach 9000 or a percentage growth of 17.7. The report further reveals that it will be necessary for organized

Continued



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Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed — *often in a few days*. She eats well, sleeps well and soon returns to her normal activities.

Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood — no “seesaw” effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient — *they often aggravate anxiety and tension*.

And although amphetamine-barbiturate combinations may counteract excessive stimulation — *they often deepen depression*.

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Acts swiftly — the patient often feels better, sleeps better, within a few days.

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Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function — frequently reported with other antidepressant drugs.

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Composition: 1 mg. 2-diethylaminoethyl benzoate hydrochloride (benaetyzine HCl) and 400 mg. meproamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

^Deprol^®



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Health Career Conference —a Stimulating Auxiliary Project

*A. W. CAVINS, M.D.
Terre Haute*

The women's auxiliaries to various state and county medical associations have several projects which they pursue and cause to prosper, in the interest of their husbands and in the cause of medicine and its duty to the public. CALIFORNIA MEDICINE for October, 1960, contains, as usual, a page devoted to the Auxiliary, but the report itself is unusual, as a perusal of it will show. Whether this would be practicable for every county society auxiliary is problematical, but the idea is certainly intriguing, and appears to work well in San Francisco—that Arabian Nights city.

Another Worthwhile Project

It is my plan, from time to time, to present to the doctors of California, through this page, reports of some of the county auxiliary activities—so that they may become more aware of them and the important role that they play both in public relations and community service at the local level.

Recently it was my privilege to present a report on a most worthwhile project of the San Diego County Auxiliary. This was called Health Career Conference. It is my pleasure this time to recount to you another stimulating project inaugurated by the San Francisco County Medical Auxiliary.

This program, "Meals on Wheels," the first of its kind in the West, has as its purpose the provision of prepared meals for people who live alone and who, because of incapacitating conditions, are unable to purchase and prepare the food that they need. Conceived originally as a pilot program, it has been so enthusiastically received that the Auxiliary has been encouraged to expand its provisions.

The *modus operandi* of the program is as follows: An Advisory Board consisting of physicians and interested and experienced lay personnel was organized. The customers pay \$1 for three meals—less, if they cannot afford that amount—and they receive this service twice a week. The Auxiliary hopes to increase this service eventually to five times a week. The San Francisco Homemaker Service screens and recommends the applicants. Meals are prepared by the Auxiliary members according to a diet recommended by the National Research Council and are delivered by Auxiliary members to the recipients. The Auxiliary's report on its "Meals on Wheels" program said that "the program not only meets a basic need for food, but has supplementary values related to mental health, providing personal contact for the home-bound, offering friendship and, in addition, quick referral, if need arises."

With this service, patients will be able to leave hospitals earlier and convalesce at home, thereby alleviating the bed shortage, which in turn will be helpful to the medical community.

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

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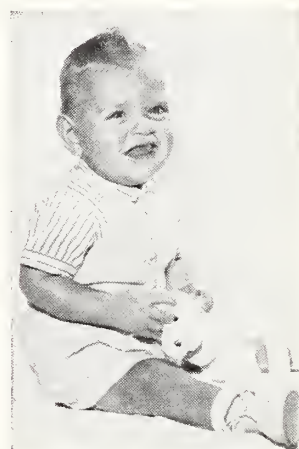
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MEDICAL PANORAMA

Continued

Also, it is an important morale factor for the elderly who can return home instead of to an institution.

Financing for the program came from the Auxiliary and the San Francisco County Medical Society. Because of the excellent publicity which this venture has received, cash donations and offers to help are constantly received by the Auxiliary.

The press and radio, which have been most co-operative, have been an important factor in the good public relations engendered. In addition, San Francisco's Mayor Christopher, an honorary member of the Committee, proclaimed September 25 as "Meals on Wheels Week." Members of the local Auxiliary of the Dental Association have been most cooperative as ambassadors of good-will. It is expected that this program will become a permanent project of the Auxiliary.

It is a privilege to commend the San Francisco Auxiliary on this worthwhile project, for it is another example of the dynamic enthusiasm of

our members, and of the cooperative spirit that exists between the Auxiliary and its parent organization, the County Medical Society. It is surely another example of the fact that our County Auxiliaries are not just spinning their wheels.

MRS. SAMUEL GENDEL

President, Woman's Auxiliary to the California Medical Association

A middle-aged man went to a doctor, complaining that he wasn't feeling just right.

"Do you drink much?" asked the doctor.

"I don't drink at all," was the answer.

"Smoke?"

"No."

"Over-eat?"

"No, I'm a light eater and don't touch starches or sweets," he replied.

"Well, what about other indulgences—women, gambling, things like that?"

"Oh, no," exclaimed the man horrified.

"You're a most unusual person," said the doctor. "What seems to be bothering you?"

"Only my back," said the patient. "I have this sharp pain from time to time across my shoulders."

The doctor smiled. "Well, that's to be expected," he said. "You're just not wearing your wings correctly."

AMA Journal, Oct. 22, 1960

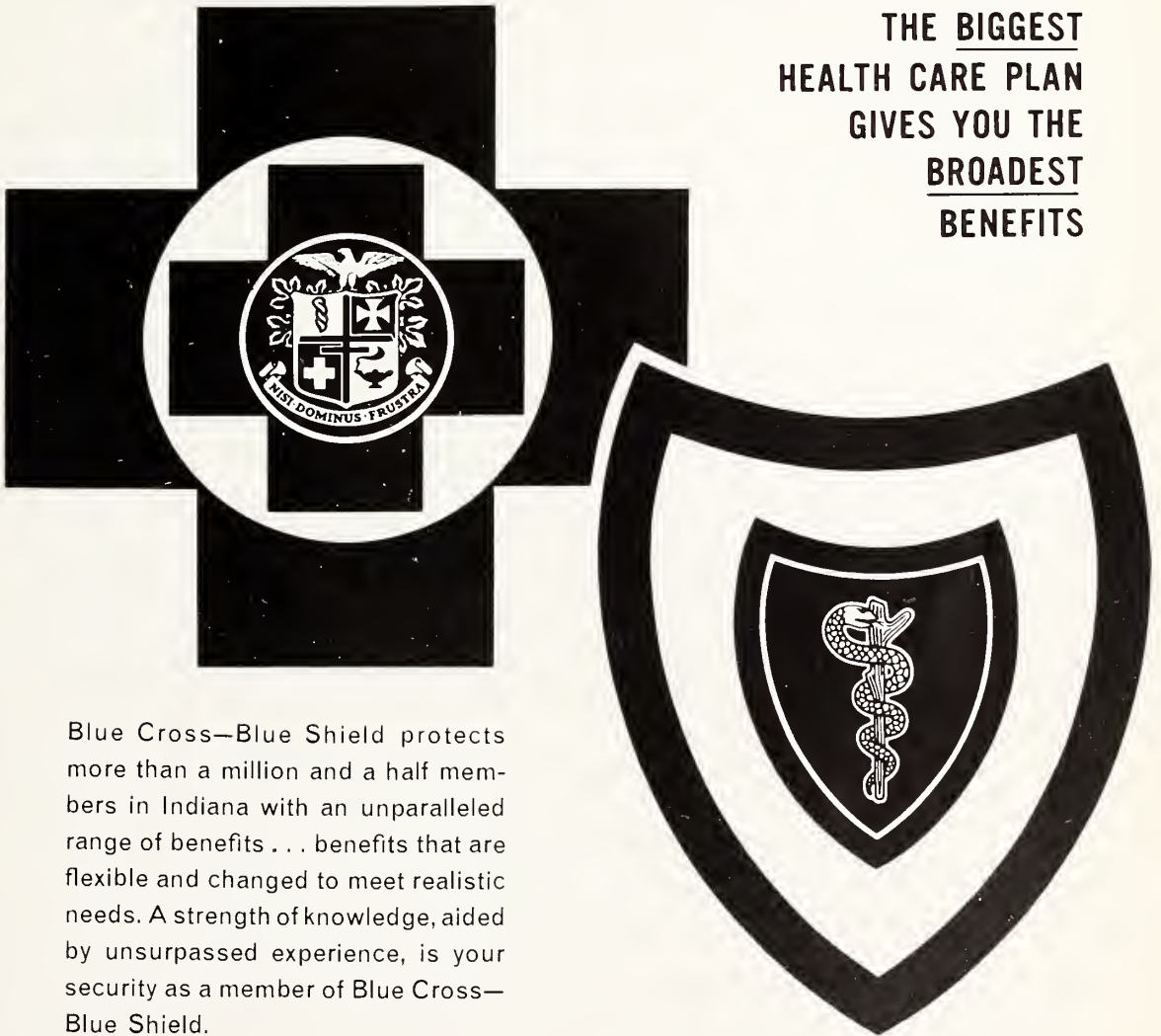


Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy.. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.



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A Prescription for Property Tax Relief

*GEORGE DOUP, President**
Indiana Farm Bureau, Inc.

THE INDIANA property taxpayer who for the last 20 years has been shouldering the growing burden of local government and school costs now has acquired the tell-tale signs of exhaustion. His cries for relief grew louder as the average property tax rate in Indiana rose from \$2.70 in 1940 to \$6.10 in 1960 per \$100 of assessed valuation. Some rates have soared well above the critical \$10 mark of terminal confiscation.

Prominent among facts uncovered in a careful diagnosis of the ills of the sick property taxpayer is that today he is paying through property taxes at least 70% of the ever-growing costs of Indiana's public schools. To complicate further and multiply the pain, the geography of property values is quite often far different from the geography of school needs or population concentrations. There is nothing organically wrong with property tax, one of the oldest forms of taxation, but it is being placed under too great a stress by the demands of a modern society for good schools and expanding government services. It is most unfair and downright unjust to expect all property taxpayers to finance this growing overload of local governmental expenses.

The Forgotten Segment

Property taxpayers are largely composed of industry, commercial establishments, professional people like doctors and lawyers, farmers and

thousands of residential home-owners. Facts show they became the forgotten segment as the crisis mounted. Farmers have especially been affected, as they have an extremely high proportion of their total assets invested in property. The present burden of property taxes has been a further aggravating factor to the harried farmer, plagued with suffocating surpluses, depressed commodity prices and choking farm costs. That is why he has demanded his Farm Bureau make a comprehensive study of property taxes and local governmental and school costs. He wanted a sound remedy and not a temporary pain reliever.

A well qualified Farm Bureau committee last year completed the diagnosis. After carefully considering all available remedies, it made a recommendation, which was further discussed in more than 900 township Farm Bureau meetings and with representatives of major parts of Indiana's economic community. It is this proposal that is being considered at the current session of the Indiana General Assembly. Every doctor who owns any property has an interest in the proposal.

Shift to Gross Income Tax

It should be explained at the outset that the proposal does not call for a new tax. Nor, does it call for an increase of total taxes collected. Basically, the proposal does effect a shift of a sizeable percentage of local school operating costs from property taxpayers to the far more numerous gross income taxpayers and also importantly it effects a distribution of costs and resources in a pattern that is just and fair for all concerned.

The proposal has three steps: (1) A county-wide property tax rate of 50 cents on each \$100

(*The Indiana Farm Bureau is a general farm organization with a current voluntary membership of more than 129,000 Hoosier families. It is the second largest membership unit of the American Farm Bureau Federation whose combined membership counts for six of every eight organized farm families in the United States.)

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Clark treated 31 anginal patients who showed signs of anxiety, fear, excitement and other forms of emotional stress. On CARTRAX, all 31 fared better than they had on previous therapy . . . as judged both by subjective reports and by reduced nitroglycerin requirements.*

CARTRAX combines PETN (for prolonged vasodilation) with ATARAX (the tranquilizer preferred for angina patients because of its safety and mild antiarrhythmic properties). Thus, CARTRAX helps you to cope with both components of angina pectoris—circulatory and emotional.

For a better way to help your angina patients relax, prescribe CARTRAX.

*Clark, T. E., in press.

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PETN[†] + ATARAX[‡] Dosage: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. For dosage flexibility, CARTRAX "20"

(pink) tablets (20 mg. PETN plus 10 mg. ATARAX) may be utilized at a level of one tablet three to four times a day. The tablets should be administered before meals for optimal response. For convenience, write "CARTRAX 10" or "CARTRAX 20." As with all nitrates, use with caution in glaucoma. Supplied: In bottles of 100. Prescription only.

[†]pentaerythritol tetranitrate [‡]brand of hydroxyzine



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PROPERTY TAX

Continued

of assessed valuation would be established and ear-marked for schools, being distributed evenly to all school corporations in the county on the basis of pupils in average daily attendance; (2) A 100% sur-tax for all gross income taxpayers in the county, except corporations, would be authorized and this would be paid at the time of the regular gross income tax reports to the state and then returned to the respective counties from which it came for 100% distribution to all school corporations in the county on the basis of pupils in average daily attendance; (3) Then, all corporations would likewise have levied a 100% sur-tax on their gross income tax reports to the state and the distribution of these monies among all school corporations would be on a state-wide basis of pupils in average daily attendance. In addition to this sur-tax portion, the state appropriation from regular gross income tax collections would be distributed on the same basis of pupils in average daily attendance. Thus, every school corporation from these sources would have an average of about \$350

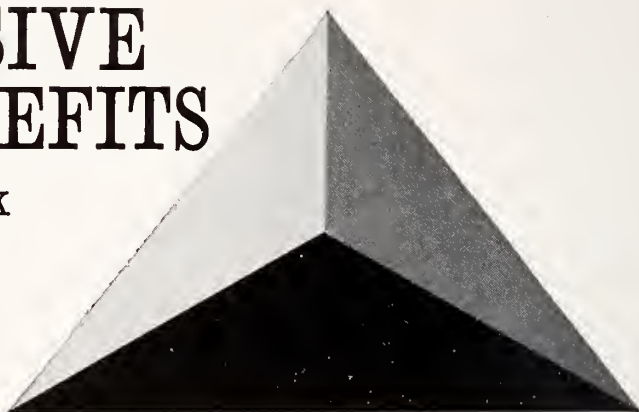
per pupil for school operation, which approximates the present average for schools in Indiana.

What does this do for all taxpayers? Property taxpayers could expect an average of 35% reduction in property taxes paid. Gross income taxpayers would find their payments doubled. This is about the size of the property tax relief achieved in 1932 when the gross income tax was first enacted.

The first step of the proposal constitutes a qualifying rate on property tax and has the first equalizing effect in that the total taxable wealth in the county would be evenly distributed for the support of each school pupil. Step 2 would be an intermediate equalizing factor, and more important, it would actually shift school operating costs at the local level from property tax to gross income tax. Steps 1 and 2 would be required as the local qualifying effort before state aid would be offered in step 3. Step 3 would increase state aid to more than 50% of the cost of the basic school operation from the present 30%. The gross income sur-tax collections from corporations would be used by all schools in the state on an equal participating

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as Calcium Ascorbate 50 mg. • L-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as CaHPO₄) 35 mg. • Phosphorus (as CaHPO₄) 27 mg. • Fluorine (as CaF₂) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K₂SO₄) 5 mg. • Manganese (as MnO₂) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as Na₂B₄O₇·10H₂O) 0.1 mg. Bottles of 100, 1000.

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Each
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Capsule contains:

ANTIBIOTIC	
TETREX (tetracycline phosphate complex equivalent to tetracycline HCl)	125 mg.
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Aspirin	150 mg.
Phenacetin	120 mg.
Caffeine	30 mg.

ANTI-HISTAMINIC
BRISTAMIN (phenyltoloxamine citrate)..... 25 mg.

Dosage: Adults: 2 capsules 3 or 4 times a day for 3 to 5 days.

Children: 6 to 12 yrs.: One-half the adult dose.

Supplied: Bottles of 24 and 100 capsules.

According to a report by the Council on Drugs of the American Medical Association,* antibiotics may be administered for prophylaxis against secondary bacterial invaders in the following types of patients with influenza: pregnant women; debilitated infants; older individuals; patients being treated for other bacterial infections with chemotherapeutic agents, and patients with chronic, nonallergic respiratory disease.

*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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PROPERTY TAX

Continued

basis rather than being a direct benefit only to the county where it may have been collected.

\$350 for Each Pupil

Each school corporation, according to this proposal, would be guaranteed annually \$350 for each pupil in average daily attendance.

State aid would vary one county to another. The average amount to be distributed by the state would be about \$180 per pupil. The formula for distributing funds for transportation would continue as it now is. It should be remembered that this is a tax reform or tax adjustment proposal, resulting in the downward adjustment of property taxes and upward adjustment of the gross income taxes. It is not a program to raise additional taxes. Local control of schools would not be affected.

Last year the Farm Bureau study group took a long look at alternative taxes, such as a sales tax and a net income tax. It was found it would take a three percent general sales tax to raise what the gross income tax is now doing or a six percent sales tax to relieve property tax-

payers to the extent outlined in the proposal. It would take a two percent net income tax, with no deductions or exemptions, to equal collections of the present gross income tax or a four percent net income tax to meet the tax relief requirement. Both of these were considered inferior to what we now have in the gross income tax. Actually the gross income tax is much like a net income tax for wage-earners and persons on salary. Also, it functions like a sales tax on transactions for business concerns. No new or additional tax collecting machinery is needed for the property tax relief proposal. ◀

The irrespressible Mr. Taber had fun telling about the mountain boy home from college whose pa asked, "Watcha larnin', son?"

The boy said, "Well, Pa, I'm studying English."

"That's good, son."

"And I'm studying algebra."

"That's fine, son. Say something in algebra."

Not wanting to let the old man down, the boy studied a minute, then pronounced solemnly, "Pi-R-Square."

The old man exploded.

"If that's what they're larnin' ye, you kin stop school right now. Ever'one knows pie are round. Cornbread are square."—Leo Aikman, *Atlanta Constitution*.

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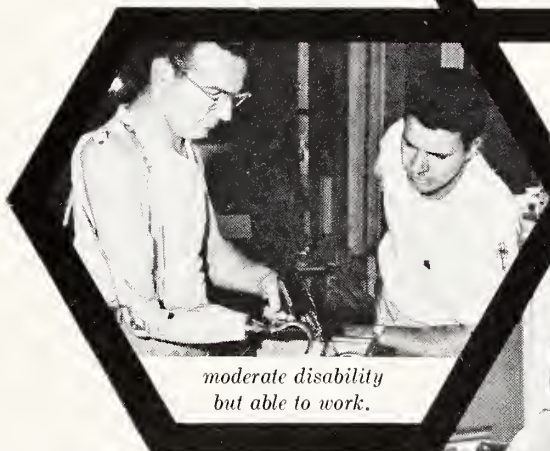
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*Direct Inquiries to:
Bernard J. Michels, M.D.
Director*

ABSTRACTS, REVIEWS

Continued

THE CHANGING IMAGES OF DOCTORS TODAY

Woodrow Wirsig, Editor, *Printers' Ink*, New York.

How often lately have each of you heard someone say "Oh, you are a wonderful doctor." Often? I hope so, for every person likes to be needed. But I'm sorry to say that no matter how often an individual may praise you, society in general is changing its attitudes about doctors.

What we might call "an increasingly bad image" about doctors is emerging. This image can, if unchanged, interfere with doctor's work, with the continuing progress in medicine which doctors have come to expect automatically from our social order, and with his future as a scientist.

Now, what do I mean by "image"? We in communications are using "image" to mean *something that people think is so—whether it really is or not.*

I wanted to find out what the changing images of doctors are today. So I made another survey. This is the third survey I've done on this subject in the last two years. My purpose each time was for an address to a major medical group.

My first survey was among editors of important magazines published nationally in America. Editors are sensitive to what their readers are thinking and want. Besides, they feel a responsibility to help educate their readers.

Community Status

My second survey was to find out how the doctor and his wife are regarded in their communities.

This third survey was made a month ago. I talked with two groups of people:

1. A group of educated people, those who had at least an A.B. degree from college. Among them were teachers, business men, ministers, editors and writers and doctors themselves.

2. A group of non-professional people, intelligent but generally uneducated. They included milk delivery men, gardeners, maids, lathe workers, mechanics, service station attendants.

This survey, like the others, was a small one. I could not go to any great expense for it. But as a kind of pilot study, made carefully to elicit genuine attitudes and not what the people thought I wanted to hear, it could serve as an indication of a problem doctors would be wise to explore.

What, now, IS the image that seems to exist in people's minds?

It's interesting, to me anyway, to see how an image changes and grows. Two years ago, the editors I talked with said their readers admired doctors as scientists. But they complained that doctors were getting more impersonal. Doctors, they felt, seemed more concerned

about money than explaining an illness. These readers had a growing fear that illness would eat up all their savings.

A year ago, I found that the people in the particular community I studied admired doctors for their skill and ability. However, they not only felt that doctors didn't talk to them enough, but they also were developing *strong resentment* toward doctors. They had a right to know what ailed them, they said, and doctors brushed them off. Their resentment spilled over toward the doctors' wives.

Today, among the educated group I surveyed, I discovered that they regard doctors as better scientists than ever before. They also feel that doctors seem less prejudiced, less rigid in their thinking and approaches to illness. Doctors, they say, seem more receptive to new ideas and new techniques than ever before. Also, they feel that the doctor today regards himself as less omniscient, even more humble, in the face of widening frontiers of knowledge.

Less of Family Physician

On the other hand, they think he is much less of the family physician than ever before. They think they understand *why* doctors are this way. They believe that a doctor's growing concern for more knowledge, more work because of more patients and worry over rising costs and prices on every hand—while his own prices are difficult to raise—tend to make him what he is today. Being more remote, the doctor is less communicative. In treating his patients impersonally, he tends to increase their fears about themselves, increases their anxieties and heightens their resentment toward the doctor in personal relationships.

There's no question, of course, but that a better educated public has more curiosity. As cities, industry, living and medicine get more complex, doctors cannot always come up with a simple explanation. Pressures of time, more patients, distance, keeping up his education and work in the hospitals—all keep today's doctor from talking things over with patients as much as he wants to.

Among the people with a high school education, or less, I discovered that they now regard their doctors with outright hostility. A doctor is someone to avoid going to, if at all possible. When they do go, they regard him as a high-priced mechanic who should fix their problem with an injection. They tend to look for something, or someone, to solve their fears of high medical costs.

Favor Government Care

This introduces a new element I found this year: More than half of the people in both groups said that they wanted the Government to set up some kind of a program so they wouldn't have to worry about medical bills and ill health. It would all be taken care of for them.

This, then, is a troubled image. Clearly the people's temper seems demanding. They want something done. And this is a challenge to medicine today—a challenge to act.

All over the country, evidence is piling up that some kind of planning is necessary. Yet in most of the

Presented at Southern Medical Association-Merrell Medical Economic Symposium, St. Louis, Nov. 3, 1960; abstract of address furnished by courtesy of the Wm. S. Merrell Company.

medical journals I read I keep seeing articles that criticize change . . . they bewail the growing hostilities toward doctors. They do not face up to the problem expressed by the President's own Commission on the Health Needs of the Nation, which said "The genius for organization, so characteristic of American life in general, is conspicuous in health services by its absence. The increased complexity of health service . . . makes it increasingly apparent that some order must be achieved."

So today, the images in the minds of different segments of society present doctors with a great challenge. Their whole way of life is on the verge of being changed. Unless *doctors themselves* find a way of meeting this challenge, someone else will do it for them—probably not nearly as well as the doctors could do it themselves.

What I propose is in line with people's emerging insistence on a national purpose . . . on solving domestic and international problems without resorting to force . . . in line with a new dynamics that seems to parade American education, communications and marketing here and abroad.

Health care is a matter of right—and doctors must take the initiative in forming whatever is necessary to provide it. For if they don't someone else will.

The reasons why I urge you so vigorously to do these things on your own behalf is that I feel so strongly that I know how valuable you really are to society. You are in a great new era, a golden era of knowledge. Never has medicine been more intelligent, more skilled.

I urge all of you to apply these same skills and resourcefulness to solving some of the social and economic problems surrounding medicine today.

NATURAL HISTORY OF HYPERTENSION

Studies were made on 212 patients with various forms of hypertension. The patients were classified according to the changes in the optic fundi and the degree of target organ involvement. They were followed up for an average period of four years, the shortest follow-up interval being two years. During the period of observation the patients received no antihypertensive drug therapy but were given more general medical treatment as indicated. Those with essential hypertension showed a strikingly different life expectancy, depending upon the presence or absence of sustained uremia. In the absence of uremia, the degree of change in the optic fundi and the severity of other target organ involvement seemed to influence the patient's life expectancy.

Those with elevated diastolic blood pressure, irrespective of the degree of elevation, who manifested benign changes in the optic fundi but no evidence of target organ decompensation enjoyed a life expectancy approximating that of the general population. In view of these findings and the fact that there is often marked lability in the diastolic blood pressure of patients with essential hypertensive disease, evaluation of drug therapy should be based

upon the degree of target organ involvement and optic fundal change rather than upon the degree of elevation of diastolic blood pressure.

Hagans, J. A. and Brust, A. A.: *Am. J. Med.*, 28: 905, June, 1960. ◀

PROLONGED STEROID THERAPY IN CHILDHOOD ASTHMA

This study confirms the benefits and dangers of prolonged steroid therapy in childhood asthma and describes the difficulties of discontinuing such treatment. Thirty-nine children with disabling asthma unresponsive to routine treatment were given prednisolone continuously for an initial minimum period of 12 months. The responses, assessed in September, 1957, were good or excellent in 31 and fair in seven. One boy had died from adrenal failure and septicemia; one girl had recovered from an episode of adrenal failure; some growth suppression was noted retrospectively in seven children. From October, 1957, drug withdrawal was attempted in every child. Sixteen months later 11 of 13 severe and eight of 25 moderately severe cases still needed steroids regularly. Eight of the "weaned" children had been off treatment over 12 months, 11 an average of nearly seven months.

Anderson, J. P.: *Am. J. Diseases of Children*, 100: 341, Sept., 1960. ◀

COOK COUNTY GRADUATE SCHOOL OF MEDICINE INTENSIVE POSTGRADUATE COURSES

STARTING DATES — WINTER-SPRING, 1961

Surgical Technic, Two Weeks, April 17
Surgery of Calan & Rectum, One Week, March 6
Gallbladder Surgery, Three Days, April 17
Surgery of Hernia, Three Days, April 20
General Pediatrics, Two Weeks, May 1
Electrocardiography & Heart Disease, One Week, April 17
Diagnostic Radiology, Two Weeks, April 3
Board of Surgery Review, Part II, Two Weeks, March 6
Gynecology, Office & Operative, Two Weeks, April 10
Vaginal Approach to Pelvic Surgery, One Week, March 27
Obstetrics, General & Surgical, Two Weeks, March 13
Fractures & Traumatic Surgery, Two Weeks, March 6
Practical Cystoscopy, Ten Days, by appointment
Surgery of the Hand, One Week, April 17
Advances in Medicine, One Week, March 13
Urology, Two Weeks, April 17

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Results of Special Hospital Study

(One of a series prepared by Blue Cross-Blue Shield)

Are there any differences between the services provided by hospitals to patients who are Blue Cross-Blue Shield members, to those having commercial insurance, or to those who have no protection and pay privately?

Are there any differences in the charge per day, the length of stay or the payment per procedure?

Recently the Actuarial Division of Blue Cross-Blue Shield conducted a special hospital study in search of answers to the above questions. For the purpose of this study a large hospital was selected, one that has adequate library records, and operates on a machine billing system.

So that comparison might be made from nearly standard cases, it was decided to study the results under two surgical procedures, two medical classifications and normal deliveries.

Except for normal deliveries, the sample utilized in the study included all admissions for the procedures and classifications selected which occurred during a recent six-month period.

The distribution was as follows:

Medical—Diabetes	164 cases
Medical—Arteriosclerotic heart disease	59 cases
Surgical—Hernia	260 cases
Surgical—Gall bladder	181 cases
Normal Delivery	393 cases

Here are the significant findings of the study:

1. There was no real difference in the charge per day made by the hospital for patients who were protected by Blue Cross-Blue Shield, by commercial insurance companies, or who paid privately. In addition, the charges per day for ancillary services such as x-rays and drugs did not vary significantly.

2. The length of stay for surgical and medical cases for patients covered by commercial insurance was approximately 9/10 of a day less than it was for Blue Cross-Blue Shield patients and those paying privately. This difference in

length of stay is accounted for by the fact that commercial companies protect a lower percentage of those over 65; who tend to have more and longer admissions.

3. Comparing each procedure or classification admission group separately, the Blue Cross payment per day ranged from 20% to 35% higher than the payment by commercial insurance companies. Blue Cross paid approximately 95% of the total charges for hospital services, while commercial insurance companies paid less than 75% on an average.

4. The days per case for normal deliveries were higher for Blue Cross-Blue Shield members than for the other two categories. The higher average in this case is apparently due to the fact that Blue Cross-Blue Shield membership includes a much higher percent of mothers in the age group over 30.

5. Mothers under 20 are generally not enrolled in either Blue Cross-Blue Shield or commercial insurance. The following table shows the distribution of cases and days for maternity care for mothers under 20:

	Total Days In Study	Total Days For Mothers Under 20	Cases— % Of Total
Blue Cross-Blue Shield	630	26	4.4
Commercial Insurance	328	51	7.5
Private Pay	408	120	30.0

This study was based on a significant sample of cases, but the sample was taken from one hospital. The study does yield some significant answers to the questions asked at the beginning of this article, but the conclusions drawn relate only to this particular hospital. To generalize with regard to the total population we need to study a much larger sample including patients admitted to all the larger hospitals. There is no doubt but that further study in this area is needed.

W. C. Huddleston
Public Relations Division ◀

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New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

Codeine phosphate 15 mg.—to relieve local and generalized pain and control dry cough

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Acetylsalicylic acid 300 mg. (5 grains)—to reduce fever and relieve aching

Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

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Wanted: Locations Physicians

Following is a list of physicians who have made inquiry at our office during the months of November and December 1960 concerning openings in our state for practice.

General Practice

- James K. Nicholson, M.D., 10 Glehe Road East, Toronto, Ontario, Canada.
Joel Vanderglas, M.D., Springfield City Hospital, Springfield, Ohio.
Angelo B. Capaccio, M.D., 2614 Hudson Blvd., Jersey City, N. J.
Richard F. Hatton, M.D., 603 4th USAF Dispensary, Box 328, San Francisco, Calif.
Larry L. McCallister, M.D., 181 East Graves Ave., Monterey Park, Calif.

Specialists

- Frederic O. Epp, M.D., 110 West 6th, Augusta, Kansas—*Industrial Medicine*.
Julian B. Coleman, M.D., 8010 East Dr., N. Bay Village, Miami Beach, Fla.—*Anesthesiology*.
Marciano T. Olivo, Jr., M.D., 6822 rue Chatelain, Montreal, Quebec, Canada—*Anesthesiology*.
Charles R. Perry, M.D., B-4307-I O'Donnell Hts., Fort Riley, Kansas—*Internal Medicine*.
William L. Treacy, M.D., 1516 4th Ave., N.W., Rochester, Minn.—*Internal Medicine*.

- Charles L. Tyler, M.D., USAH, Carlisle Barracks, Carlisle, Pa.—*Internal Medicine*.
John Balhuizen, M.D., 90 W. Northwood, Columbus, Ohio—*Internal Medicine and Pulmonary Dis.*
Allen B. Malnak, M.D., 1015½ Brown St., Evanston, Ill.—*Internal Medicine*.
Walter C. Goldstein, M.D., 2010 Ramblewood Rd., Baltimore, Md.—*Internal Medicine*.
Bernd Bruno Bach, M.D., Harlan Memorial Hospital, Harlan, Ky.—*Internal Medicine*.
Nathan A. Ridgeway, Jr., M.D., 2438D South MacGregor, Houston, Texas—*Internal Medicine*.
Richard A. Kuteipal, M.D., Madigan Gen. Hospital, Tacoma, Wash.—*Obstetrics and Gyn.*
Vincent Ricciutti, M.D., 709 Druide Lake Dr., Baltimore, Md.—*OB-GYN*.
Michael Lado, M.D., 999 Monroe Avenue, Apt. 707, Memphis, Tenn.—*OB-GYN*.
Charles D. Breedlove, M.D., Indian Hospital, Fort Defiance, Ariz.—*OB-GYN*.
Hershel L. Clemmons, M.D., 139 North Oak St., Clarksville, Ind.—*OB-GYN*.
Karl T. Baumgaertel, M.D., Milledgeville State Hospital, Milledgeville, Ga.—*Neurology*.
Leonard J. Quetsch, 140 Le Moyne Avenue, Washington, Pa.—*Surgery*.
James S. O'Hare, M.D., 104 W. Madison, Baltimore, Md.—*General Surgery*.
Neville Sender, M.D., Good Samaritan Hospital, Dayton 5, Ohio—*OB-GYN*.
Robert G. Small, M.D., Codfish Hill Rd., Bethel, Conn.—*General Surgery and General Practice*.

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HEART ASSOCIATION ACCEPTING RESEARCH SUPPORT APPLICATIONS

Applications for research support are now being accepted by the Indiana Heart Association, it was announced recently by Dr. Kenneth G. Kohlstaedt, chairman of the Association's research committee. Deadline for applications is April 1, 1961.

Grants will be effective, in most cases, July 1, 1961 and will be made for grant-in-aid and fellowship support.

Applications and further information can be obtained by contacting the Indiana Heart Association, 615 North Alabama St., Indianapolis, or writing to the research committee at the same address.

During 1960-61 the Association allocated \$92,000 to support 15 cardiovascular disease research projects in Indiana institutions.

AEC to License Ohio State Reactor

The Atomic Energy Commission intends to license a nuclear training reactor for Ohio State University at Columbus. It will be used primarily for student training in reactor physics and engineering, and will also produce low activity isotopes. The reactor is a 10 kilowatt pool-type, to be fueled with enriched uranium.

Mead Johnson Reorganized Into Three Autonomous Divisions

Mead Johnson and Company is now organized as three autonomous operating divisions. Mead Johnson Laboratories will be concerned with nutritional and pharmaceutical products to be advertised and promoted only to physicians and pharmacists and sold only through drug stores.

Edward Dalton Company will deal with nutritional products, of which Metrecal is an example, to be promoted to both the medical profession and the public and sold through drug stores and other channels.

Mead Johnson International will handle the international operations of the corporation. Lambert D. Johnson, Jr., former Vice-President and General Manager of Mead Johnson International, and Dr. W. D. Snively, Jr., former Vice-President and Medical Director have both been promoted to two newly created Executive Vice-Presidencies.

J.A.M.A. Plans Wider Regional Coverage

J.A.M.A. Journal has announced plans for a revised format which will include wider coverage of regional news, physician honors and appointments and other notes of interest. The editors encourage county societies and other news sources to submit material to the News Editor, *J.A.M.A.*, 535 N. Dearborn St., Chicago 10. They wish the articles to be as timely as possible, and will use suitable photographs with the copy.

Husband, Wife, formerly of N.I.H., Join I.U. Medical Faculty

Appointments to the faculty of the Indiana University School of Medicine of a husband and wife, Drs. Arthur D. Merritt and Doris E. Merritt, both from the National Institutes of Health in Washington, D.C., were announced recently by Dr. John D. VanNuys, University medical dean.

Dr. Arthur D. Merritt will become associate professor of medicine. A graduate of George Washington University and its School of Medicine, he has been chief of the medical investigations section of the National Institute of Dental Research and a teacher in the George Washington medical school.

Dr. Merritt, the wife, will be assistant professor of pediatrics and director of medical grants and contracts. She was graduated from Hunter College, and received her medical degree from George Washington. Since 1957 she has been executive secretary of the cardiovascular study section of the National Institutes of Health.

Both appointments, approved by the University's board of trustees, were effective Jan. 1. Salaries will be paid from research grants to the School of Medicine.

November Hill-Burton Status Lists 68 Completed Projects

The status of Hill-Burton grants for Indiana, as of November 30, included 68 projects, costing \$72,748,393, with a \$23,828,304 federal contribution and supplying 3,166 additional beds, completed and in operation.

Twenty-nine projects, costing \$35,047,601, including a \$9,077,335 federal contribution and supplying 1233 additional beds were under construction.

Widely-Known Writer, Editor Dies

Dr. Laurance D. Redway, widely known medical writer and editor, passed away in November after a brief illness.

A former editor of the Westchester Medical Bulletin, Dr. Redway was editor of the *New York State Journal of Medicine*, a post which he has held since 1952.

He was widely known as a medical historian, having written the History of the Westchester County Medical Society, which remains as the authentic record of the oldest society in the state of New York.

AEC Now Permits Tritium on Watches

The Atomic Energy Commission now permits the use of tritium on the hands and dials of luminous watches and clocks. Tritium (hydrogen 3) is a radioactive material that emits no penetrating gamma radiation and whose low energy beta particles do not have enough energy to penetrate a watch crystal or the insensitive outer layer of the skin. It produces much less radiation than radium used in the same fashion.

Chest Physicians Help Cuban Members

The Board of Regents of the American College of Chest Physicians, at a November meeting, resolved to establish a relief fund for Cuban members of the college who have been temporarily exiled from their country.

They voted to contribute \$5,000 to launch the fund, and are now soliciting contributions. The Cuban chapter of the College, founded in 1940, includes 74 members.

JOINS A.A.G.P. HEADQUARTERS STAFF

William R. DeLay, former press relations manager for Mead Johnson and Company, has joined the headquarters staff of the American Academy of General Practice as assistant for public relations.

DR. TETHER RE-ELECTED

Dr. J. Edward Tether, of Indiana University School of Medicine, has been re-elected assistant secretary of the Medical Advisory Board of the Myasthenia Gravis Foundation.

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FUTURE MEETINGS, SEMINARS, COURSES

Medical Tour of Israel

Constitutes Clinical Postgrad Program

A medical tour of Israel constituting a clinical postgraduate program will be offered by University of California Extension's department of continuing education in medicine, April 20-May 15.

Offered as a part of an effort toward the furtherance of international cooperation in the field of medicine, the sessions have been planned in cooperation with a committee from the Hebrew University Hadassah School of Medicine in Jerusalem, and the Beilinson Hospital and Tel-Hashomer Hospital in Tel-Aviv.

Opportunities will be provided for physicians to observe the rapid development of modern medical care in Israel and to become acquainted with staff members of the three institutions. Outstanding Israeli physicians will discuss management of some of the unusual tropical diseases as well as more common problems in internal and tropical medicine. Patients will be presented whenever possible.

Participants will go by airline, and stopovers have been provided in Paris, Istanbul, Athens and Rome. Sightseeing trips to the major points of interest in each area have been arranged.

Inquiries concerning the Israel tour may be addressed to: Dean of Continuing Education in Medicine, UCLA Medical Center, Los Angeles 24, Calif.

Bunts Institute Offers Course in Arterial Vascular Disease

The Frank E. Bunts Educational Institute, affiliated with Cleveland Clinic Foundation, has announced that it will offer a course in Recent Advances in Arterial Vascular Disease, March 1 and 2 in Cleveland.

The course, to be presented by staff members of the Cleveland Clinic Foundation, will include three guest speakers: Ray W. Gifford, M.D., Consultant, Section of Medicine, Mayo Clinic; Ormond C. Julian, M.D., Ph.D., Professor of Surgery, University of Illinois; Clark H. Millikan, M.D., Consultant, Section on Surgery, Mayo Clinic.

Registration will be limited to 125, and acceptances are made on the basis of order of application. There is no charge for interns and residents. Applications should be mailed to the Education Secretary at the Institute, 2020 E. 93rd St., Cleveland 6.

Essex County Surgical Clinic Set for April in Ontario

April 26, 27 and 28 are the dates set for the Annual Essex County Surgical Clinic, sponsored by the Essex County Medical Society in Windsor, Ontario.

Among the outstanding teachers taking part are Prof. Ian Aird, University of London and Dr. Robert M. Zollinger, Ohio State University.

Further information may be obtained from the Registrar, Essex County Surgical Clinic, 301 Canada Building, Windsor, Ont.

Electronics-Electrical Techniques Session Planned for July in New York

The 4th International Conference on Medical Electronics combined with the 14th Annual Conference on Electrical Techniques in Medicine and Biology will be held in New York City at the Waldorf-Astoria, July 16-21. Additional information may be obtained by writing Institute of Radio Engineers, 1 E. 79th St., New York City.

CLINICAL REVIEWS

Mayo Clinic and Mayo Foundation

ROCHESTER, MINNESOTA—April 10, 11, 12, 1961

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery.

The American Academy of General Practice and the College of General Practice of Canada have advised the Committee on Clinical Reviews that up to 21 hours of Category I credit may be obtained by members of the American Academy of General Practice or the College of General Practice of Canada attending.

There are no fees for this program.

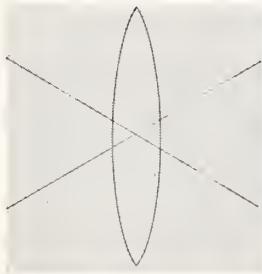
The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with the Clinical Reviews Committee, Mayo Clinic, Rochester, Minnesota.

CARDIOLOGY MEETING SCHEDULED

The American College of Cardiology is scheduled to meet at the Biltmore Hotel, New York, May 16-20. Dr. Philip Reichert, 350 Fifth Ave., Empire State Building, New York 1, may be contacted for further information.

Neurologists to Meet

Members and guests of the American Academy of Neurology will meet in Detroit, at the Sheraton-Cadillac Hotel, April 27-29. Those interested may contact the executive secretary, 4307 E. 50th St., Minneapolis 17. ◀

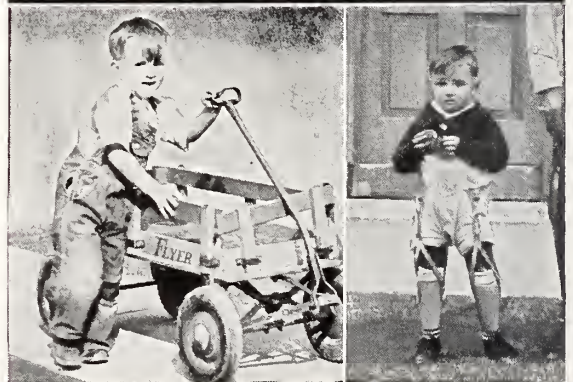


VISION BEFORE PROGRESS

"Where there is no vision the people perish." The Bible tells us this, and its truth has never been more apparent than in the world today. Vision is a prerequisite to planning, but White-Haines has been planning for vision for more than a half-century. Fine ophthalmic craftsmanship, prompt service, your utter confidence in the exacting execution of the lens prescription you write . . . that's the credo of White Haines. It took vision to plan for that ultimate, too.

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Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.

Deaths

Richard Henry Callahan, M.D.

A 47-year-old Lake County physician, Dr. Richard H. Callahan, passed away Dec. 16 at his East Chicago home.

Dr. Callahan, a general practitioner, graduated from Rush Medical College in 1938. He was on the Staff of St. Catherine Hospital, East Chicago, and was Indiana Department head of the American Medical Veterans' Association.

Donald Manuel, M.D.

A former Edinburg and Franklin physician, Dr. Donald Manuel, passed away Nov. 1 at his home in Redding, Calif. He was 45.

Richard R. Owens, M.D.

Dr. Richard R. Owens, widely known Muncie cardiologist, passed away Nov. 22. He was 50.

A 1933 graduate of Harvard University, Dr. Owens interned at Presbyterian Hospital, Chicago, later served in New York's Bellevue Hospital and was a fellow at the University of Pennsylvania Hospital. He began practice in Muncie in 1944.

Dr. Owens was on the staff of Ball Hospital, Muncie, and consultant at Mercy Hospital, Elwood, and at Blackford County Hospital, Hartford City.

Harold W. Shonk, M.D.

Dr. Harold W. Shonk, 41-year-old Noblesville general practitioner, passed away Dec. 12.

A graduate of the Indiana University School of Medicine in 1944, Dr. Shonk was former president and secretary of the Hamilton County

Medical Society. He served as delegate to ISMA in 1957.

Dr. Shonk was on the staff of Riverview Hospital, Noblesville. He served in the Air Force as flight surgeon from 1945-47.

Howard Stellner, M.D.

A 50-year-old Fort Wayne psychiatrist, Dr. Howard A. Stellner, passed away Nov. 19 at a Fort Wayne Hospital.

Dr. Stellner graduated from the I.U. School of Medicine in 1935 and began practice in Fort Wayne in 1946. At the time of his death he was a member of the ISMA Commission on Governmental Services.

He was consultant at V.A. Hospital, Fort Wayne, on the staff at Fort Wayne School, and V.A. Regional examiner and examiner for Allen County Court. He served as secretary, treasurer and president of Parkview Hospital staff in Fort Wayne.

Dr. Stellner served in the Army Medical Corps for four years during World War II, as psychiatric ward officer and chief of service.

Frederick C. Warfel, M.D.

Dr. Frederick C. Warfel, senior ISMA member, passed away at his Indianapolis home Nov. 11 at the age of 80.

Dr. Warfel, a graduate of Physio-Medical College in Indianapolis, had practiced general medicine in Indianapolis for 30 years. He was a veteran of both world wars.

In ISMA, Dr. Warfel served on the Committee to Study the Problems of Quackery and Nostrum Consumption in 1914-15 and the Committee on Medical Economics in 1916. ◀

County Society News

Adams

Thirteen members of the Adams County Medical Society met at Decatur Community Center Dec. 13 for a general business meeting.

Allen

Over 100 physicians registered at the eighth annual Road Show of the Indiana Academy of General Practice and the Fort Wayne Medical Society, Dec. 6 at Fort Wayne.

Special speakers were Dr. Donald B. Effler, Chief of the Department of Thoracic Surgery,

Cleveland Clinic Foundation, and Dr. Richard H. Ferguson, Consultant in Medicine at Mayo Clinic.

Cass

Newly-elected officers of the Cass County Medical Society are Drs. E. J. Fogel, Logansport, president; Richard Glendenning, vice president and Clarence Cobb, secretary-treasurer. Dr. E. W. Bailey will be delegate to state convention; his alternate is Dr. D. K. Winter.

Continued

COUNTY NEWS

Continued

Fayette-Franklin

Dr. Perry Seal, Brookville, has been elected president of the Fayette-Franklin Medical Society. Assisting him will be Drs. William Kerrigan, vice-president; J. L. Steinem, secretary-treasurer; G. T. Waterson and Dr. Seal, delegates; and Dr. Frank Neukamp, representative on the hospital board of trustees.

Floyd

Thirty members of the Floyd County Medical Society met at New Albany Dec. 9 for a general business discussion.

Fountain-Warren

Ten members of the Fountain-Warren Medical Society gathered at the Attica Hotel in Attica on Dec. 1 for a business meeting.

Fulton

Dr. William J. Rusler, Rochester, has been elected secretary of the Fulton County Medical Society.

Gibson

At a meeting in Princeton Dec. 14, 18 members of the Gibson County Medical Society discussed pertinent business matters.

Hamilton

Dr. Paul Waitt, Sheridan, will serve as secretary of the Hamilton County Medical Society during 1961.

Howard

Dr. Max W. Rudicel has been elected president of the Howard County Medical Society. Assisting him during 1961 will be Drs. John H. Alward, vice president; Walter M. Behn, Jr., secretary-treasurer; Garvey B. Bowers, delegate and Frederick C. Schwartz, alternate. All are from Kokomo.

Jay

President of the Jay County Medical Society for 1961 is Dr. A. C. Badders. Also elected to offices were Drs. Ralph M. Steffy, vice president; H. Joseph Cronin, secretary-treasurer; William H. Cripe, delegate and F. E. Keeling, alternate, all of Portland.

Knox

Members of the Knox County Medical Society gathered with local pharmacists for their annual joint dinner, Dec. 20.

LaGrange

Dr. Kenneth Lahman, Topeka, is the new president of the LaGrange County Medical Society. Other officers include Drs. Philip E. Yunker, vice president; Harley F. Flannigan, secretary-treasurer; Dr. Yunker, delegate and Dr. Lehman, alternate delegate.

Lawrence

Nineteen members of the Lawrence County Medical Society met at Bedford Dec. 7 for a general business session.

Morgan

Newly-elected officers of the Morgan County Medical Society are Drs. W. P. Winter, Martinsville, president and Alan Johnston, Martinsville, secretary.

Noble

Dr. Dale Mattmiller, Arvilla, is the new president of the Noble County Medical Society. Also elected at a recent meeting were Drs. Herman Hepner, vice president; Frank W. Messer, secretary-treasurer, Robert Bryan and J. R. Nash, delegates.

Owen-Monroe

Mr. Alfred Meyer presented a film on "The Doctor Defendant" at the Nov. 27 meeting of the Owen-Monroe Medical Society at Bloomington.

Dr. John M. Miller is the new society secretary.

Perry

Six members of the Perry County Medical Society met at Cannelton Dec. 6 for a general business session.

Porter

Dr. John Hoyt, Medical Director of Adult and Child Guidance Clinic at LaPorte County, spoke at the Nov. 29 meeting of the Porter County Medical Society concerning the guidance clinic.

Officers, elected at the Dec. 27 meeting, are Drs. Theodore Makovsky, president; Charles G. Griffin, vice president; Thomas J. Covey, secretary-treasurer; Ralph Eades, delegate and J. R. Frank, alternate.

Putnam

Dr. William R. Tipton will serve as president of the Putnam County Medical Society in 1961. Assisting him will be Drs. Dick Steele, vice president; and Anne S. Nichols, secretary.

Continued

COUNTY NEWS

Continued

Scott

Dr. Carl Bogardus, Austin, is the newly-elected president of the Scott County Medical Society. Assisting him are Drs. Marvin McClain, vice president; James A. Sabens, secretary-treasurer; Dr. McClain, delegate; and Dr. Bogardus, alternate delegate.

Shelby

Dr. W. R. Tindall is the new president of the Shelby County Medical Society. Other newly-elected officers include Drs. W. L. Dalton, vice president; James H. Tower, Jr., secretary-treasurer; P. R. Tindall, delegate, and Dr. Dalton, alternate delegate.

Starke

Dr. Guy B. Ingwell has been elected president of the Starke County Medical Society. Other officers are Drs. J. F. DeNaut, vice president; Earl R. Leinback, secretary-treasurer, Dr. Ingwell, delegate, and Dr. DeNaut, alternate.

Tipton

Newly-elected president of the Tipton County Medical Society is Dr. Meredith B. Gossard. Assisting him are Drs. W. A. Kurtz, vice president; and Robert L. Holler, secretary-treasurer.

Vigo

Dr. Paul F. Zwerner is the new president of the Vigo County Medical Society. Also named to offices were Drs. Arnold W. Kunkler, vice president; Hubert T. Goodman, secretary-treasurer; C. L. Luckett, trustee and Dr. Kunkler, board of censors. Dr. Norman Silverman was reelected delegate and Dr. James V. White, alternate delegate.

Wayne-Union

Dr. Peter Coggins, of the University of Pennsylvania Department of Research, spoke on Chemo-Therapy in Cancer at the Dec. 14 meeting of the Wayne-Union Medical Society.

Wells

Dr. Harold F. Falls, from the Department of Ophthalmology at the University of Michigan, spoke on Developmental Anomalies of the Head and Neck at the Nov. 21 meeting of the Wells County Medical Society.

New officers elected by the Society are Drs. Pierre C. Talbert, president; Charles E. Jackson, vice president and S. Bruce Kephart, secretary-treasurer. ◀

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Commission Meetings

VOLUNTARY HEALTH AGENCIES

December 11, 1960

The members of the Commission who attended were Drs. Wendell A. Shullenberger, James Gosman, Franklin Bryan, Louis C. Bixler, Walfred A. Nelson and Norman Booher. Guests were Guy A. Owsley, M.D., Harry R. Stimson, M.D., Mr. John B. Twyman, Mr. Howard Grindstaff; representing the Marion County Cancer Society, Mr. Ralph C. Werner, Executive Secretary, and Mrs. John T. Lindquist, Chairman of the Board; representing the American Cancer Society, Indiana Division, Mr. William Cordell, Executive Secretary; and Muscular Dystrophy, Mr. John T. Deifel; Ind. Soc. for Crippled Children, Mr. Fred Beckman, President, and Mrs. E. A. Chatham; Indiana State Tuberculosis Society, Mr. Chester D. Kelly; Indiana Heart Association, Dr. Robert Yoho and Mr. Robert H. Patty; Cerebral Palsy, Mr. Nachon H. Keljik; The National Foundation, Mr. Larry Eberlein and Mr. Larry Kruddop; Mental Health, Mr. Brown, executive secretary.

Luncheon was enjoyed somewhat late, due to the bad weather. After luncheon, the chairman introduced the members of the commission present, and, in turn, introduced each of the representatives of the Voluntary Health Agencies present, as guests, as listed above.

The President of the Indiana State Medical Association, Dr. Guy A. Owsley, greeted the group, as well as President-Elect, Harry R. Stimson, M.D.

The policy of this commission was set forth by the chairman by reading the resolution included in paragraph 3a of the Agenda.

Health Agencies, in developing policy, should define its position relating to voluntary health agencies in order to guide the Commission in its work, and

WHEREAS, Voluntary Health Agencies are firmly established in the pattern of American life, and contribute much to the wellbeing of all citizens, and

WHEREAS, strong medical guidance and leadership is necessary for the best efforts of all voluntary health agencies if they are to function to the best advantage of the medical profession and the people they are intended to serve, now

THEREFORE, BE IT RESOLVED, that the Commission on Voluntary Health Agencies of the Indiana State Medical Association go on record as recognizing that while voluntary health agencies, like most other organizations are not perfect, they have a definite worthwhile value to the people in the communities they serve, and, we, therefore, in principle, approve them and

BE IT FURTHER RESOLVED, that the Commission urges the members of the Indiana State Medical Association to become affiliated and active on the state and local level in voluntary health organizations in order to give them the

proper medical leadership and guidance they need to perform the greatest service to medicine and the people of the areas they serve, and
BE IT FURTHER RESOLVED, that the members of this Commission who have accepted specific assignments to the various Voluntary Health Agencies make every effort to contact these agencies and become well informed in the work of these agencies.

The chairman also referred to the Guides listed in paragraph 3b of the agenda, and read certain sections of this contained in the bottom of page 74 and top of page 75. This policy was explained as covering the reason for today's meeting.

MUTUAL OBLIGATIONS BETWEEN MEDICAL SOCIETIES AND VOLUNTARY HEALTH AGENCIES

The medical society and the voluntary health agency adhere to universally accepted moral and ethical practices in performing their work. Since each is engaged in community health protection, the recognition of mutual obligations and the promotion of mutual understanding is imperative.

Among such mutual obligations are the following:

1. Liaison should be arranged between medical societies and health agencies by the selection of physician members of the agencies' governing bodies from physicians suggested by, or known to be acceptable to, the medical society.

2. The medical society and the health agency should jointly establish basic policies regarding medical care, preventive medicine and all matters involving physicians and their relations to the agency, its members, and its clients.

3. There should be cooperative program planning in terms of local, state, and national needs and joint evaluation of accomplishments.

4. An agency should comply with the "Principles of Ethics of Fund Raising" formulated by the National Social Welfare Assembly and be willing to have its accounting procedures audited by appropriate auditors in order to establish confidence in its financial integrity.

5. There should be mutual exchange of information and opinion so as to permit the medical society and the agency to understand and accept each other's policy and practice.

There was a brief recap of a similar meeting between these groups held on December 13, 1959, and the abstracts from the tape made on this occasion were referred to several times throughout the discussion.

The commission next introduced a proposed Bill for enactment before the General Assembly of the State of Indiana, as attached to these minutes. Also, discussed at the same time was a set of criteria for official recognition of Voluntary Health Agencies on the part of the Indiana State Medical Association. A voluminous discussion followed on this possible legislation, and the chairman called on each of the voluntary health agencies present for their comments. It seemed that this legislation would be accepted with at least good grace by all of the agencies represented but as the discussion proceeded it became evident that the agencies

were becoming more and more willing to set up a self-policing council of voluntary health agencies to do the job for which this legislation would be introduced.

After all the discussion was finished, the chairman called for an executive session of the commission and a verbatim report of this session follows:

Executive Session Commission on Voluntary Health Agencies

Members present: Norman Booher, Walfred Nelson, Franklin Bryan, James H. Gosman and Wendell Shullenberger.

The chairman of the commission asked each member of the commission to comment on the facts brought out at the meeting and on the course of action this commission should take.

DR. GOSMAN: I think in view of the fact that the time is so short, the fact that these organizations present today have indicated their willingness to cooperate with us, the fact that in order for them to reach any final conclusions that they would have to present this to their boards for their action and feelings and because of possible things that were brought up at the meeting regarding the legislation, the question of whether it is legal from the supreme court angle and all that sort of thing, I think it would behoove us at this time to perhaps try the second suggestion that was made that some sort of an organization such as perhaps even this commission or and with representatives from other units to go over annual reports and to publicize these papers such as they do in Los Angeles as a trial and if that did not succeed to proceed with legislation.

DR. SHULLENBERGER: The apparent willingness of the representatives of organizations here at the meeting this afternoon to try to develop an overriding group of representatives from within each of the organizations and others not represented here to regulate and do their own policing with the help of the medical profession, which it was suggested that they could certainly count on having, seems a reasonable basis upon which to proceed with the suggestions

brought out by Dr. Gosman in the statement just preceding mine and I would be in favor of following Dr. Gosman's lead in this respect.

DR. NELSON: After our meeting this afternoon I believe it is the consensus of opinion of the visiting members of Voluntary Health Agencies that there is something odious in legislation and each one implies that they are not informed enough at the present time of their national associations to allow us to go ahead without having further testimony from them. At this time I would be in complete agreement with Dr. Gosman and Dr. Shullenberger to allow all these agencies to set up a central agency to police themselves under our supervision.

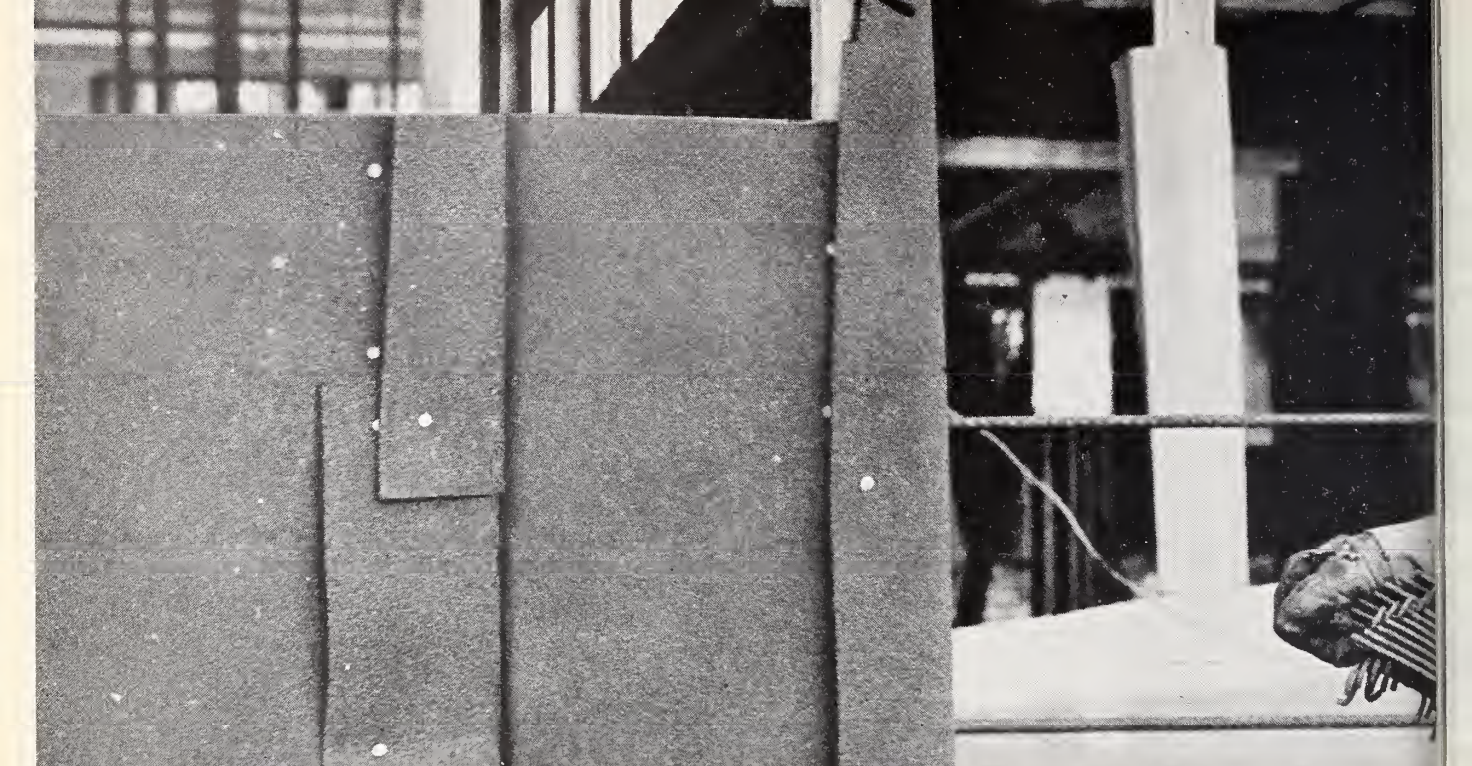
DR. BRYAN: Rather than review what has already been said by the previous speakers, members of the commission, I will also agree to consider the recommendation by Dr. Gosman.

DR. BOOHER: I summarize then, gentlemen, as chairman of the commission, that your consensus of opinion at this meeting is that we should accept the alternative of asking them to set up some such organization as a joint council of voluntary health organizations which would accomplish the things which we had in mind in the possibility of introducing legislation, and in which we can assure that they will have the full cooperation of the Indiana State Medical Association. I also gather from your expressed opinion that it is not your good judgment that we take the total responsibility of policing agencies in the State Association but to act as a catalyst to make them do it themselves.

It is the consensus of this commission, also, that this commission should take the lead in getting these organizations back together in the reasonably near future to attempt to perfect this organization. It is felt that there is certain expediency because the threat of legislation hangs over these organizations and they are more likely to agree to such an arrangement than they would be after we can no longer introduce legislation covering the subject.

Meeting was adjourned at 5:00 P.M.

Norman R. Booher, M.D.
Chairman



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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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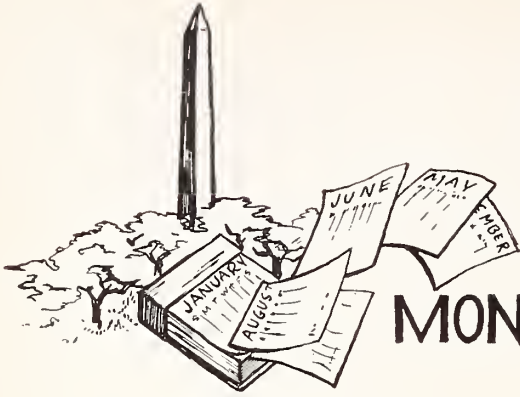


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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—President Kennedy asked Congress to increase social security taxes to finance limited medical care for elderly persons on the social security rolls, a plan opposed by the medical profession.

The proposal was part of a sweeping health program outlined by Kennedy in a special message to Congress during the first month in the White House.

The Kennedy program also included federal aid for construction and operation of medical schools, scholarships for medical and dental students, grants for community nursing and hospital services, stepped-up medical research and expanded federal activity in the field of child and youth health.

Under Kennedy's proposal, social security beneficiaries 65 years and older could get up to 90 days of hospitalization for each single illness. However, the patient would have to pay \$10 daily for the first nine days of hospitalization with a minimum payment of \$20.

After release from a hospital, the elderly person could get up to 180 days in a nursing home. The social security program also would provide for payment by the government of all out-patient diagnostic costs in excess of \$20 and community visiting nurse services.

The program would be financed by increased social security taxes by one-fourth of one percent on both employers and workers and by three-eighths of one percent on self-employed persons covered by social security. The social security tax base also would be increased from the present \$4,800 a year to \$5,000.

Enactment of this proposal, coupled with another Kennedy recommendation and increases in the social security tax already scheduled in the law, would mean that workers and employers would be paying \$250 each in social security taxes in 1969.

Nationwide television audiences were told by the American Medical Association spokesman why the medical profession supports the Kerr-Mills program of medical care for the aged and opposes tying it in with social security.

Continued on page 290



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In television debates with Sen. Hubert Humphrey (D., Minn.) on NBC-TV and Walter Reuther, organized labor spokesman, on CBS-TV, Dr. Edward R. Annis of Miami, Fla., described the Kerr-Mills program as "sound and effective." He said it "must be given the chance it deserves."

"Congress passed it because it believed that the important thing was to help the people who need help; to help them quickly; and to help them through the machinery of local government," Dr. Annis said.

NETWORK CHARGED WITH DISTORTION

The AMA Board of Trustees charged the CBS network with "misrepresentations, bias, and distortions" on another program: "The Business of Health—Medicine, Money and Politics."

The network edited out of the taped program the AMA's true position on health care for the aged:

"The AMA believes that any medical care plan is both unsound and unfair which would compel working people to shoulder increased social security taxes to finance health costs of all those over 65 (under social security), rich and poor alike, regardless of whether they want or need

Continued on page 294

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such help and which, at the same time, ignores millions of indigent elderly who do need help."

SCOPE OF PROGRAM VIEWED WITH ALARM

Kennedy's health program faced strong opposition in Congress. The consensus of Capitol Hill observers was that it stood a 50-50 chance of getting Congressional approval but not before it had been cut down. There were some who doubted that the Administration's program for medical care of the aged would be acted upon, at least by both houses of Congress, before next year.

Even some Democratic Congressmen with the liberal label were taken aback by the scope of Kennedy's health program.

Arthur H. Motley, President of the Chamber of Commerce of the United States, warned that social security taxes are being increased to a point "where people might rebel against the whole Social Security system."

He contended that this nation's present personal medical care system is the best of any large nation.

"It's worth crusading for and that is what the Chamber is doing," Motley said. ◀

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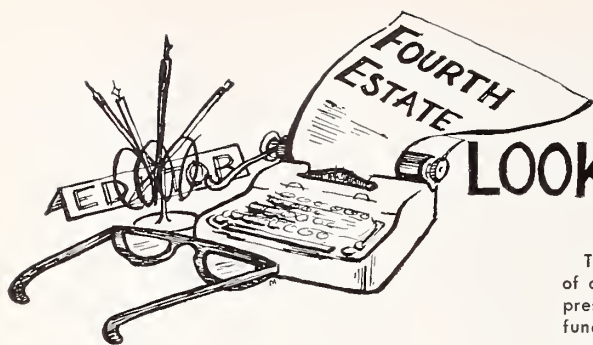
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Aiding Senior Citizens

Congress may decide to finance medical care for the aged through the social security system by increasing the social security tax rate. The White House Conference on Aging, which held a four-day meeting in Washington last week, decided to recommend this method of paying for medical care, although the recommendation will come from separate groups of conference delegates rather than from the conference as a whole. Because of conference rules, all the delegates were not permitted to vote on the question, and the recommendation thus is inconclusive, for there was considerable opposition to the plan.

Yet, regardless of what came out of the conference, Congress seemed likely to tie the program in with social security. A task force appointed by President-elect Kennedy has endorsed the plan, giving it a further boost. This would mean replacing the Kerr-Mills Medical Aid for the Aged Law which was passed by Congress last September and which provides for joint federal and state action to give medical aid to the elderly who need it.

Those opposed to medicine under social security feel that the Kerr-Mills law will meet the needs of aged persons who must have help, and at much less cost to the taxpayers. One sound feature of this law is that it doesn't propose to supply medicare for persons able to pay their own bills. The Kerr-Mills Law hasn't yet been given a chance to show what it can do.

Advocates of the social security approach argue that the Kerr-Mills Law does not provide adequate aid. They deny that the social security method would constitute socialized medicine.

While the social security method may make

considerable sense on the surface, it is its implications that are disturbing. While it is geared to only one segment of the population—the aged—what is to prevent it from being extended to other segments, such as the young, later on? What then is to stop the advent of socialized medicine for everyone?

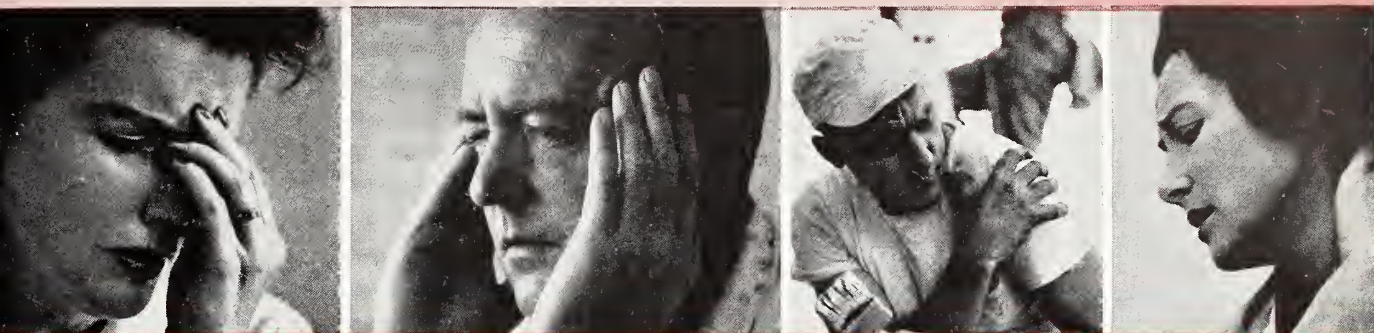
With all segments of the population eventually drawn under social security medicare, the cost to the government (which means the cost to the people) could become astronomical. This would be in addition to the rapidly growing private medical care programs being set up by insurance companies.

Estimates are that at the outset the plan would cost \$1 billion a year in new social security payroll taxes and that within five to 10 years the cost would double the \$2 billion annually. The path that is being charted could become a policy of complete dependence on the government. We should think seriously of what this may lead to—a curb on individual initiative and incentive to provide for one's own needs, and a consequent loss of the values of self-reliance, not to mention medicine controlled by the government, which could conceivably be used by some future dictatorial government as a political whip over the people.

Socialization of medicine can be another blow at private enterprise, and private enterprise is one reason for America's greatness.

There is no question that elderly persons whose means are meager need and deserve financial help in their illnesses, and the government has already moved toward helping them by enacting the Kerr-Mills Law. The fact that this law would require recipients to take a means test to show whether they could pay for their

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FOURTH ESTATE

Continued

own care does not seem objectionable. Why should those well able to pay for their own care be given a free ride at the taxpayers' expense?

Kokomo Tribune

Jan. 15, 1961

Medical Care Dispute

No sooner had Dr. James T. Cook been chosen "general practitioner of the year" by the American Medical Association than he openly disagreed with the official AMA views on medical care for the aged. The disagreement is not important in itself, but it does usefully sharpen the focus on public attention on an important subject.

The new law, endorsed by the AMA, authorizes federal help (in participating states) to aged persons unable to pay for medical care. Dr. Cook describes this as "a form of blackmail" which forces a state to match a federal grant in order to get it. He apparently fails to take into account two facts—that federal grants can go as high as 80% in low-income states, and that in some cases states will have to put up no new money at all but will be credited with amounts already being spent on public assistance.

Dr. Cook is by no means entirely at odds with the group that honored him. He joins the AMA in opposition to proposals which would finance medical care for the aged through increased social security taxes. Of late the AMA has been re-sharpening this opposition, rightly anticipating another fight in Congress.

The issue involved is one of broad public interest. The AMA's official views are entitled to respect, but they are not necessarily the last word on this or any other aspect of medical economics. The arguments for and against both the AMA-endorsed law and the social security approach should be considered with care. It is on the basis of such consideration, not on the basis of emotional commitment to this or that point of view, that Congress ought to decide.

Terre Haute Star

Jan. 1, 1961

Snow Tires and Chains

Scientific experiments which discover and test the new just as frequently confirm the value of the old. Too often, it seems, we are motivated by wishful thinking and are prone to hope for too much from new productions.

This is something to bear in mind as we face another winter driving season—because this is what is revealed after a series of tests conducted by the Committee on Winter Driving Hazards of the National Safety Council.

Ever seeking a more effective solution to the problem of stalled traffic and skidding accidents on snow- or ice-covered roadways, the committee has tested many types of special traction tires—tires with various tread designs or compounds, tires with abrasive or breakout materials imbedded in the rubber, and so on.

The search has not been entirely fruitless. Skid tests have shown that winter tires have been developed to a point where they provide aid when driving in snow conditions of mild or medium difficulty and when grades are not too steep. Their use for winter driving, to the honest extent of their help, is recommended by the committee.

Snow tires are not a cure-all, however. The tests also proved that the old tried and true traction safeguards—regular tire chains, or their modern counterpart, reinforced tire chains, known and appreciated by many experienced and realistic drivers—continue to be needed. They alone pass all tests, including performance in the often more difficult weather conditions.

Our police department cites the following impartial findings of the National Safety Council's Committee on Winter Driving Hazards: "Concerning starting and pulling ability on glare ice, snow tires are 28% better than regular tires; regular tire chains are 231% better, while reinforced tire chains are 409% better. On loosely packed snow the snow tires were 51% better than regular tires, whereas reinforced tire chains provided 313% better traction."

For winter stopping ability, the police department cited the following from the research report: "On glare ice, at only 20 mph, braking distances for regular tires average 195 feet. Snow tires take 174 feet, regular tire chains 99 feet, reinforced tire chains 77 feet. At the same 20 mph speed on loosely packed snow, regular

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FOURTH ESTATE

Continued

tires stopped in 60 feet, snow tires 52 feet, regular tire chains 46 feet and reinforced tire chains 38 feet."

Kokomo Tribune
Dec. 14, 1960

Less Emphasis on Quality?

The American Medical Association is pressured by the State Department to co-operate for an increase in the number of foreign doctors in this country. The State Department, which naturally is concerned with foreign relations, is disturbed because 2,481 foreign doctors have failed to pass the tests that would qualify them for service as interns or resident doctors in United States hospitals.

We need more doctors in this country. Our own medical schools are not graduating enough. A question pointed up by the State Department intervention on behalf of foreign-educated doctors who can't pass the tests for U. S. practice is whether our domestic medical standards should be down-graded to increase the number of doctors.

The test which the 2,481 flunked was given by the Educational Council for Foreign Medical Graduates. The council is sponsored by the American Hospital Association, the Association of Medical Colleges, the Federation of State Medical Boards and the American Medical Association.

Because, impliedly, the AMA has the most influence the State Department pressure is on it. An aggressively "liberal" newspaper accuses the AMA of "arrogance" because it dared to tell the State Department that a week or 10 days was needed to consider the request for action to help the 2,481 test flunkers.

A fact that needs some emphasis is that thousands of other foreign-educated doctors passed the test.

Foreign relations have great importance. The shortage of doctors in this country is serious. But medical standards also are important.

Let's hope that the bars aren't lowered so much in the service of international politics and to abate the doctor shortage that the quality of medical service is minimized.

South Bend Tribune
Nov. 27, 1960

The Need for Medical Help

The Indiana Hospital Association has added its voice to the many asking for wholehearted Indiana co-operation with the medical care for the aged plan passed by the last Congress.

Often a hospital cares for a patient who cannot pay. Human life cannot be repossessed by a debt collector.

Who pays when the patient can't? All the sources that may go into a hospital's income—more fortunate patients, donors, taxpayers.

But this is more than a problem in hospital administration.

This is a case of health and dignity for old people who cannot afford to be sick, but cannot help being sick.

It has been estimated that 10,000 Hoosiers not otherwise aided could get help through this program.

They would be able to pay hospitals and private doctors with this aid.

Congress initiated this program.

But the General Assembly must follow through.

If it fails, Hoosier taxes will support medical aid for the aged in other states—but not at home.

Indianapolis Times
Nov. 30, 1960

Other Proposals for the Aged

The White House Conference on Aging had something to say about a good many other programs for the elderly. It urged, for example, an end to compulsory retirement at age 65. This is something the government ought not get into, for retirement policies are properly the prerogative of business management. Management feels that its supervisory ranks should be reinvigorated from time to time by the promotion of youthful leaders. Many businesses, however, are finding places for those over 65 who are still vigorous and valuable.

A ceiling on outside earnings for social security recipients should be kept, but it ought to be raised from time to time, the conference recommended. This is a reasonable view, for rising costs of living hit retired people as well as those still working.

Continued

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FOURTH ESTATE

Continued

Another sound recommendation was that relievers past 65 who are drawing old-age assistance should be allowed to earn up to \$50 a month without penalty. It is commendable when a retired person is willing and anxious to go on earning.

Other good recommendations were that tax incentives should be encouraged to promote private savings for retirement, and that nursing homes should be accredited the way hospitals are.

The conference proposed that state residence requirements for relief grants be abolished, but this is a debatable matter. The purpose of residence requirements is to prevent persons from taking advantage of the relief benefits, which is done by a good many moving from state to state.

The conference might well have urged, also, that more efforts be made to provide meeting and recreation centers for older citizens. This is a growing movement, with more and more communities doing it.

Kokomo Tribune
Jan. 15, 1961

Seat Belts for Safety

The furor about seat belts for driving safety that developed a few years ago has subsided. This is not good.

The belts have tremendous safety value. They can save lives when traffic accidents occur. They can make non-fatal injuries less serious.

Two surgeons who collaborated on a report delivered in an American Medical Association clinic estimate that 10,000 Americans killed in traffic accidents last year would be alive now if they had been wearing seat belts.

"If you have them and don't wear them," the surgeons summarized, "it's like letting your insurance payments lapse. If you don't have them it's like driving without insurance."

Most car owners do not buy seat belts. Many drivers and passengers in cars equipped with the belts do not use them. Actually, every car should be equipped with them and they should be used, even on short trips.

Nobody can feel confident of immunity to death or injury in a traffic accident. Seat belts,

of course, do not avert accidents but they reduce the chances of death or serious injury when accidents occur.

The latest authoritative estimate, included in the paper read in the AMA clinical conference, is that a person wearing a seat belt when a traffic crash occurs is 40 to 60% less likely to be killed or seriously injured.

In view of the incidence of traffic accidents and the grim toll in deaths and injuries every day it really is surprising that more Americans are not alarmed enough to protect themselves with seat belts.

South Bend Tribune
Dec. 16, 1960

Not Enough Doctors

LaPorte Herald-Argus: Does the United States have enough doctors? Are there enough students entering medical schools these days to fill future needs?

The Association of American Medical Colleges claims that declining medical school applications and rising costs to both students and institutions have led "to a crisis stage."

The association further contends that increasing costs of a medical education constitute a formidable barrier to lower income and lower middle income groups.

Indiana with only one medical school is in the lower bracket of states in the number of doctors per 100,000 people. The Indiana ratio is below 100 for each 100,000, whereas the national average is 118.

Without any doubt, the major answer is the creation of many millions of dollars worth of scholarships for qualified students with medical aspirations. Unless this is done, the shortage in the decade ahead will become more than merely serious.

Indianapolis Star
Dec. 7, 1960

There are men and classes of men that stand above the common herd: the soldier, the sailor and the shepherd not infrequently; the artist rarely; rarer still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization.

Robert Louis Stevenson: *Underwoods, Dedication*

Continuation of Heart Issue

Epidemiological Studies of Cardiovascular Diseases

HENRY M. PARRISH, M.D.*

Indianapolis

NOWADAYS ONE FREQUENTLY sees reference in the medical literature to the "epidemiology" of this or that disease. Although medical pioneers such as Hippocrates, Thomas Sydenham, John Hunter, Edward Jenner and John Snow were interested in epidemiology, this method of studying diseases fell into disuse after the "germ theory" became established. The idea that disease resulted from "multiple causes" involving the agent of the disease, man and his environment was replaced by the concept of a "single cause" such as a specific type of bacteria. Today we know that disease processes are not that simple. During the past 60 years, epidemiology has undergone profound changes. Students and practitioners of medicine should become acquainted with epidemiological methods—old and new.

Formerly, epidemiology was defined as the study of epidemics. Actually, the word is derived from the Greek—*epi* (on or upon) and *demos* (the people). This implies a disease or a condition inflicted upon the people. Whereas, the

unit of study in clinical medicine is the individual patient, the unit of study in epidemiology is a population group. Thus, epidemiology is the study of health and disease in a human population. It may be considered a basic science of public health and preventive medicine.

Gordon¹ stated that, "Along with clinical medicine and experimental pathology, it (epidemiology) is one of three general methods by which progress is directed toward improved prevention and a better clinical management of disease." These three methods of study complement each other. However, in general, no significant decrease in morbidity and/or mortality from a disease can be accomplished until methods for controlling that disease are applied to a large segment of the population. Epidemiology is no longer limited to the study of infectious diseases. Chronic, presumably noninfectious, diseases such as lung cancer,^{2, 3} diabetes mellitus,⁴ peptic ulcer,⁵ automobile accidents⁶ and rheumatoid arthritis⁷ are being studied by epidemiological methods.

The purpose of this paper is to review briefly several epidemiological studies of cardiovascular

* Medical Director, Marion County General Hospital.

diseases, to show how they have been used to study and control these diseases, and to indicate how they are helpful to the medical practitioner and to his "population of patients." The everyday practice of preventive medicine should be the goal of every physician.

Congenital Heart Disease

With the decline in perinatal deaths resulting from prematurity, diarrhea and infectious diseases, congenital malformations have become an important cause of perinatal mortality. Gregg,⁸ an Australian ophthalmologist, first observed the clinical association between congenital cataracts and maternal rubella. Swan and Tostevin⁹ noted that German measles early in pregnancy also was associated with congenital heart disease and deafness. Subsequent epidemiological investigations¹⁰ confirmed that the German measles virus produced teratogenic effects. Krugman and Ward¹¹ found that gamma globulin given soon after exposure to rubella would neutralize the virus.

Thus, in maternal rubella we have a classic example of how a clinical observation was confirmed and defined by epidemiological investigations and how laboratory studies provided the answer to the prevention of this teratogenic virus. It seems likely that other forms of congenital heart disease are caused by environmental factors including infectious diseases and nutritional deficiencies.

Rheumatic Heart Disease

Rheumatic heart disease, a complication of rheumatic fever, is intimately related to hemolytic streptococcal infections. Therefore, the epidemiology of rheumatic heart disease is a facet of the epidemiology of hemolytic streptococcal infections. For the past 80 years, physicians observed that acute tonsillitis epidemics frequently were followed by epidemics of rheumatic fever. Following Lancefield's¹² classification of streptococci, Group A beta hemolytic streptococci were identified as etiological agents in rheumatic fever.

Epidemiological studies,¹³ primarily among school children and military personnel, provided important facts about the distribution of rheumatic fever, about host susceptibility to the disease and about various environmental factors which allow the disease to spread. Studies of Coburn and Young¹⁴ and Rammelkamp et al.¹⁵ in military populations are particularly note-

worthy. Epidemiological studies showed that about three percent of individuals lacking a history of rheumatic fever develop the disease following Group A hemolytic streptococcal respiratory infections. On the other hand, the attack rate among persons with a history of previous rheumatic fever may be 50% or greater.

Clinical trials using antibiotics to treat streptococcal infections and thus to prevent initial attacks of rheumatic fever were conducted in high-risk population groups. Use of antibiotics to prevent the initial attack of a disease is called *primary prevention*. Moreover, large groups of patients with rheumatic fever and rheumatic heart disease were given prophylactic antibiotics on a long-term basis to prevent recurrent attacks of the disease. The use of antibiotics to prevent recurrent attacks of a disease is called *secondary prevention*. Thus, epidemiology aided in providing the basic data for the prevention of an acute disease (rheumatic fever) and a chronic disease (rheumatic heart disease).

Syphilitic Heart Disease

In times past, syphilis and syphilitic involvement of the cardiovascular system were widespread. Untreated syphilis may attack the aorta, aortic valves, coronary arteries and occasionally the myocardium. A landmark in the history of syphilis was the development of a serological test for syphilis in 1906 by Wassermann, Neisser and Bruck. This diagnostic test, and other more recently developed tests, allowed epidemiologists to conduct "serological surveys" among population groups to find cases of untreated syphilis.

Mahoney, Arnold and Harris¹⁶ in 1943 introduced penicillin to treat syphilis. This provided a great advance over mercury, bismuth and arsphenamine in the treatment of syphilis. As a result of advances in laboratory diagnosis, improved epidemiological case-finding techniques (such as premarital, prenatal, and pre-employment examinations) and antibiotics, deaths resulting from syphilis and cardiovascular complications of syphilis have declined. Syphilitic heart disease formerly accounted for about 5 to 25% of all heart disease cases. Today syphilis probably accounts for less than one percent of all cases of heart disease in most parts of the United States.¹⁷

Diphtherial Heart Disease

Diphtheria is another infectious disease in which heart involvement has led to death in a

high proportion of the cases. Diphtheria or "throat distemper" epidemics were frequent in the United States before about 1900. Sporadic outbreaks have occurred since then. The Klebs-Loeffler bacillus produces an exotoxin which causes myocarditis. Wesselhoeft¹⁸ reported that about 59% of diphtheria deaths result from acute myocarditis. In 1890 Von Behring and Kitasato developed an antitoxin for diphtheria. Schick¹⁹ in 1913 found a simple test to measure diphtheria immunity by injecting small amounts of toxin intracutaneously. Then in 1923, Ramon²⁰ showed that formalin-treated toxin could be used for active immunization against the disease. The Schick test has been used extensively to measure the diphtheria immunity of individuals and large population groups.^{21, 22}

It is a tribute to American physicians, especially general practitioners and pediatricians, that routine immunization of infants and children with diphtheria toxoid (alone or in combination with tetanus toxoid and pertussis vaccine) has made diphtheria and diphtherial myocarditis a disease of the past. This practice, however, must be continued to avert sporadic epidemics.

Coronary Heart Disease

In the United States, England and Western Europe coronary heart disease among middle-aged males has reached an epidemic level. During the past four decades the death rates for "arteriosclerotic heart disease, including coronary disease" have increased, while the death rates for most other causes have declined. Most authorities believe that this represents a "real" increase in the disease which cannot be explained entirely by an aging population, improved diagnosis and better medical care.

Clinical, pathological and laboratory studies have not provided all of the answers about the multiple factors associated with coronary heart disease and they have not suggested effective ways to control and prevent it. Epidemiology, which has been so successful in the control and prevention of typhoid, diphtheria, smallpox and tetanus, is now being used to study coronary heart disease. There is reason to believe that many important advances in our understanding of coronary heart disease will result from these epidemiological studies.

What epidemiology attempts to do is to study the distribution of a disease in a population to determine who is most likely to develop the dis-

ease and how they differ from people who do not have it. Human and environmental factors associated with the disease are elicited. Oftentimes these factors provide valuable clues about the cause or causes of the disease.

Several epidemiological studies of coronary heart disease are cited. Sauer and Enterline²³ analyzed death certificates and showed that there is a definite geographic pattern for coronary heart disease in the United States. The highest coronary death rates were found in the north-eastern states, in other states with large metropolitan areas and in some of the South Atlantic States. Dawber and associates²⁴ are studying the epidemiology of coronary heart disease by means of a long-term, follow-up of the population of Framingham, Mass. These investigators found that high blood pressure and hypercholesteremia were associated with the development of coronary heart disease. Similar prospective (long-term) studies of coronary heart disease are being conducted among civil service employees in Albany, N. Y.²⁵ and Los Angeles, Calif.²⁶ and among a sample of the general population used in the California Health Survey.²⁷ These prospective studies are expensive, difficult to organize and time-consuming, but they should prove very valuable.

Keys²⁸ has studied dietary fat consumption and serum lipid levels among selected population groups in various countries to correlate these findings with coronary heart disease morbidity and mortality rates. He believes that the fat content of the diet plays an important role in the development of coronary heart disease. Morris et al.²⁹ in a study of London transport-workers found evidence which suggested that physical activity of work may be protective against developing coronary heart disease.

Progress is being made in epidemiological studies of coronary heart disease. However, this is a difficult disease to study for the following reasons: relatively far advanced coronary atherosclerosis cannot be measured, as yet, during life; the "incubation" or latent period for this disease probably covers 30 to 50 years rather than a few days or a few weeks as is the case for most infectious diseases; there is no specific test, such as the Schick test or the tuberculin test, to determine susceptibility to the disease; and present evidence suggests that there are multiple predisposing, precipitating and necessary factors in-

volved in the etiology of the disease. The ultimate aim of clinical, laboratory and epidemiological studies is to prevent coronary heart disease just as rheumatic heart disease, syphilitic heart disease and diphtherial heart disease can be prevented.

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Pneumococcal Meningitis, Endocarditis and Rupture of the Aortic Valve: A Case Report

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Indianapolis

Better cure rate for pneumococcal meningitis makes heart complications more evident.

BACTERIAL ENDOCARDITIS during or following pneumococcal meningitis is not an uncommon finding and is said to occur approximately 25-30% of the time.^{1,2,3} However, the high mortality in adults in this form of meningitis⁴ has not allowed this type of endocarditis to be too apparent.

Today, with the use of high doses of penicillin^{5,7} and steroids⁶ the mortality of this disease is less and the prognosis is more favorable. Coincident with this is awareness of the complications, such as endocarditis, most often localized at the aortic valve.³

Austrian described eight cases of rupture of the aortic valve occurring in endocarditis following pneumococcal meningitis, in the past decade.³ All except one were males, over 40 years of age. In his experience rupture of the valve occurs in approximately 20% of the cases despite adequate therapy.

Case Report

A 47-year-old Negro male was admitted to the Flower Mission tuberculosis hospital after a routine six-month roentgenogram demonstrated "slight pneumonitis or pleural effusion" on the left side on 4/18/60.

His past history is significant in that he was first diagnosed as having tuberculosis in 1956

pitalized at the Sunnyside Sanatorium three times: 1956, 1957, 1958. He had been treated with triple therapy and was discharged as arrested tuberculosis in 1958. Routine follow-up since his discharge had been satisfactory until his present admission.

Two days prior to his checkup on 4/18/60 the patient had noticed the onset of a "cold and a cough." Three days after his admission to the hospital he was transferred to the Marion County General Hospital because of a sudden rise in temperature to 106°, rapid shallow breathing, tachycardia of 130/min., a stiff neck and abdominal distention. A tentative diagnosis of tuberculous meningitis was made.

On admission to the Marion County General Hospital a lumbar puncture revealed the cerebral spinal fluid contained many gram positive diplococci which were shown to be pneumococci on subsequent culture. There were no acid fast bacilli. The patient was started on penicillin 12,000,000 u/day, sulfadiazine 4 gms/day and hydrocortisone 400 mgms/day.

By 4/23/60 the patient was clinically better, able to take oral fluids but still running a temperature of 101°. Sputa for acid fast bacilli were negative. An x-ray of the chest showed marked clearing of the pneumonitis. He had a VII nerve palsey on the left.

Temperature Still Elevated

On 5/3/60 the cerebral spinal fluid showed no increase in pressure, 184 wbc, 88% lymphocytes, sugar 53 mg% and protein 70 mg%. There were no bacteria or acid fast bacilli. The patient's clinical picture was improving despite elevated temperatures of 100-101°. He now

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because of a left pleural effusion. He was hos-

showed deafness on the left side; an EEG demonstrated no localized abnormality.

By 5/10/60 the patient had greatly improved, was eating, able to sit up and converse, but still had a slightly elevated temperature and a left VII, VIII nerve involvement. He was maintained on penicillin and sulfadiazine; hydrocortisone had been discontinued after two days.

On 5/19/60 the patient started having shortness of breath. Examination showed him to have a tachycardia 140/min. and basilar rales. No heart murmurs were reported.

Chest film taken on 5/23/60 showed an enlarged heart and increased peribronchial markings. The patient improved without any special measures. Antibiotic therapy was continued.

All meningeal and cardiorespiratory symptoms were absent by 6/9/60 and the patient had been

afebrile for 10 days. A repeat analysis of the cerebral spinal fluid was normal. Antibiotic therapy was discontinued. A repeat chest film showed general improvement of the pulmonary parenchyma but there still remained some cardiac enlargement.

The patient was seen on 6/12/60 at 12:45 a.m. with severe apprehension, profuse sweating, dyspnea, tachypnea 66/min. Examination revealed the patient to be orthopneic, pulse 180/min., BP 200/80-20, moist rales throughout both lung fields, neck veins distended and the liver down 5 cm below the right costal margin. He received morphine 15 mg IM, nasal oxygen rotating tourniquets and phlebotomy of 500 cc and started on digitoxin. An ECG revealed left ventricular hypertrophy and non-specific ST-T wave changes.

By 2:00 p.m. the same day the patient was much improved: BP 124/40-0 pulse 96/min. A grade IV systolic and diastolic murmur was heard over the entire precordium. A few basilar rales were heard.

On 6/13/60 the heart rate was 100/min. with a gallop rhythm. A machine type murmur was heard over the entire precordium. The PMI was in the sixth interspace in the left anterior axillary line. The diagnosis was acute aortic insufficiency with possible rupture of the aortic valve. Four blood cultures were negative.

Gradually Increasing Edema

After this episode of acute pulmonary edema the patient's course was one of many episodes

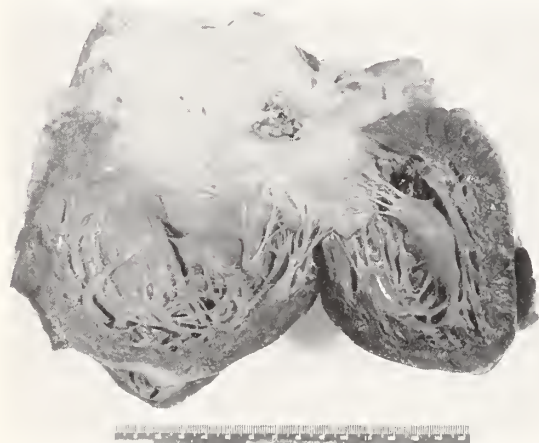


FIGURE 1
CROSS VIEW of the heart with left ventricle open.



FIGURE 2
CLOSEUP of the aortic valve showing rupture and the vegetation.

of the same, with gradually increasing generalized edema and a downhill course. It was decided to transfer him to the Indiana University Medical Center for possible cardiac surgery. However, on 6/28/60 he became anuric.

On 7/2/60 the patient was started on 600 mgs of hydrocortisone/day and started diuresing by 7/4/60. His clinical picture had improved on that day. Again it was decided to attempt to transfer him to the Indiana University Medical Center for possible cardiac surgery. However, the next day he was again in pulmonary edema. By 7/7/60 the patient's condition worsened and on 7/9/60 he died in an episode of peripheral vascular collapse.

Autopsy Findings

Gross Examination: The heart was markedly dilated and its weight was 640 gms. The thickness of the left ventricle wall was 1.3 cm and that of the right ventricle wall was 0.5 cm. Coronary arteries were moderately to markedly arteriosclerotic. Circumference of the valves were as follows: tricuspid, 16 cm; mitral, 12.5 cm; pulmonic and aortic, 9.5 cm. There was a defect in the posterior aortic cusp measuring 2.0 cm in its greatest dimension. Most of the commissure between the posterior and the left anterior cusps was absent. Several small (0.2 cm) vegetations were present on the remnant of the posterior cusp. No gross abnormalities of the myocardium were noted. The weight of the left lung was 580 gms and that of the right was 740 gms. Both had numerous adhesions over their surfaces. There was increased firmness and loss of crepitance in both lungs. Weight of the liver was 1230 gms and on sectioning the parenchyma had a "nutmeg" appearance.

Microscopic: The intima of the coronary arteries was markedly thickened and areas of calcification were present. A few small areas of necrosis were present in the myocardium. Sections from the posterior aortic cusp contained small hyalin vegetations with fibrin over their

surfaces. No bacterial colonies were found in these vegetations. In the underlying tissue there was a slight infiltrate of chronic inflammatory cells and a few polymorphonuclear leucocytes. The lungs contained much eosinophilic material and erythrocytes in the alveoli, and a slight inflammatory reaction was noted. Chronic passive congestion of the liver with a few areas of necrosis in the region of the central veins were present in the sections examined.

Summary and Conclusion

A case of endocarditis with rupture of the aortic cusp following pneumococcal meningitis is presented. Endocarditis was not suspected until the patient had acute pulmonary edema and severe aortic insufficiency. These symptoms occurred approximately one month after all signs and symptoms of meningitis had passed and despite what was considered adequate therapy.

Endocarditis should be kept in mind during or following any case of pneumococcal meningitis. Any unexplained aortic insufficiency deserves investigation for pneumococcal disease either in the immediate or remote past.^{2,3}

ACKNOWLEDGMENT

Appreciation is expressed to Dr. Emmett Pierce for his work in performing the autopsy and summarizing the pathological findings.

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Rare cardiac abnormality
may be diagnosed clinically.

Ebstein's Anomaly of the Tricuspid Valve —A Case Report

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EBSTEIN'S ANOMALY is seen infrequently. It has been reported once in every 210,000 births, accounting for less than one percent of all congenital heart lesions. Over 140 cases were reported in the literature thus far.¹

Ebstein's anomaly is described as a displaced and elongated tricuspid valve, usually with an atrial septal defect and large right atrium.

Ebstein first described the condition in an autopsied case in 1866.² By 1950, only 23 cases had been reported.³ General interest in congenital heart disease was greatly stimulated at about this time with the sudden increase in popularity of heart surgery. With more types of congenital cardiac anomalies being subjected to surgery, there was a need for a definitive diagnosis in every case. Methods of diagnosis also became more refined. It is not surprising, then, that in 1950, Ebstein's anomaly was diagnosed clinically for the first time. It is also not surprising that during the 10 years from 1950 to 1960, roughly five times as many cases of Ebstein's anomaly were reported as in the 84-year period from 1866 to 1950.

Case Report

A 58-year-old female was admitted to the Marion County General Hospital on 10-2-57 because of a week-old injury to the right thigh. She was known to have congenital, cyanotic heart disease with purported congestive failure treated with digitalis.

Physical examination disclosed an acutely ill individual with some evidence of chronic debility. Blood pressure was 100 mm Hg systolic and 50 mm Hg diastolic; apical heart rate was 80 per minute and was regular. The temperature was 99.4° F. There was generalized cyanosis with clubbing of fingers and toes. Neck veins were distended to the angle of the jaw with the patient sitting. The precordium was quiet to palpation, with the P.M.I. in the fifth interspace in the anterior axillary line. First sound at the apex was of fair quality. The second sound was split at the base and the reduplication was well-heard along the left sternal border where a definite diastolic third sound was also present. No murmurs were heard. The liver was palpable 4 cm below the costal margin. It did not pulsate.

The patient's entire right thigh was swollen. The right thigh at a point 5 inches below the superior iliac spine measured 24¼" in circumference; the left leg measured 22". There was pigmentation in the skin over the lower portions of both legs.

A blood count on admission showed a hemoglobin of 19.7 gms per 100 ml of blood and a hematocrit of 67%. Her white blood count was 6,200 per cu mm with 65% neutrophils, one percent eosinophils and 34% lymphocytes; the red blood count 6.9 million per cu mm. Urine showed a specific gravity of 1.020, a trace of albumin, and 5 to 10 white blood cells per high power field. A fasting blood sugar was 69 mg per 100 ml of blood. However, one hour after re-

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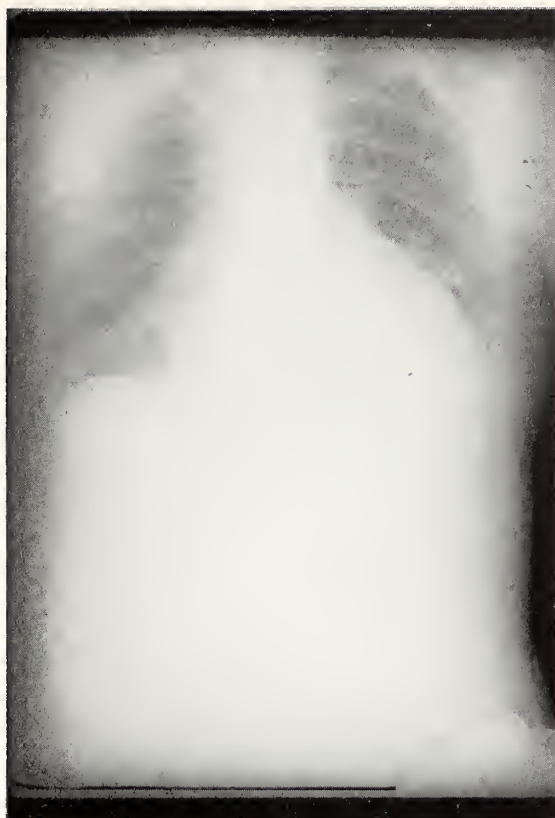


FIGURE 1

NOTE THE somewhat square appearance of the heart, the relatively small aortic arch and the normal lung markings.



FIGURE 2

THE NEARLY TRANSVERSE shadow in the middle anterior portion of the mediastinum represents the greatly enlarged right atrium.

ceiving 50 gms of glucose orally, her blood sugar went up to 256; at the end of two hours it was 216. The patient's blood urea nitrogen was 24 mg per 100 ml of blood. A culture taken from the right thigh grew staphylococcus aureus, coagulase positive.

The patient's right leg was elevated and warm packs were applied. Penicillin and streptomycin were given and she was also started on heparin and dicumarol. The diabetes was controlled by diet.

Two Phlebotomies

A phlebotomy was performed on 10-9-57 and again on 10-10-57; 500 ml of blood was removed at each phlebotomy. The patient's hematocrit went down to 48%. On 10-9-57, erythromycin was started and the streptomycin was discontinued the next day.

X-rays of the right femur including the knee revealed no abnormalities, other than some soft

10-7-27

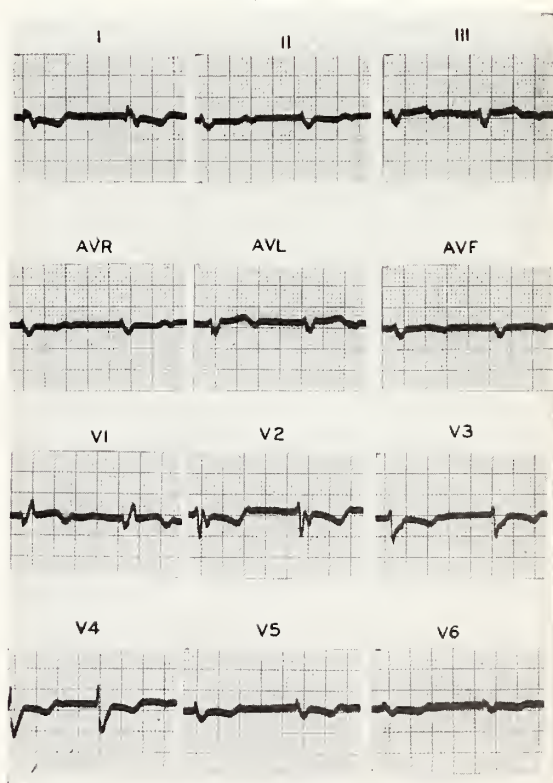


FIGURE 3

TRACING DEMONSTRATES prolonged A-V conduction (P-R measures 0.44 seconds), right bundle branch block and low voltage ventricular complexes.

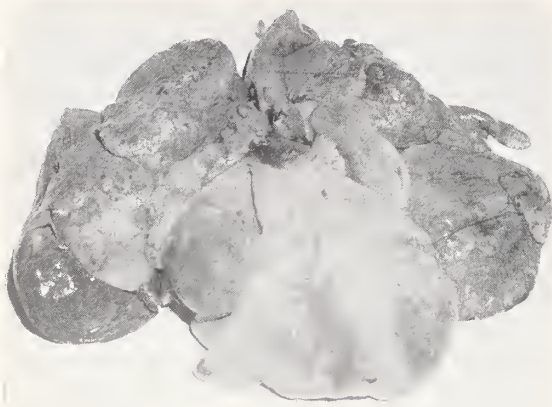


FIGURE 4
THE HEART AND LUNGS viewed from the anterior surface. Greatly distended right auricular appendage is apparent.



FIGURE 5
THE LARGE INTERATRIAL septal defect and enlarged pectinate muscles in the right atrium are clearly visible. The right ventricle is small.

tissue swelling in the mid-thigh region. X-rays of the heart showed marked enlargement in the transverse and anterior posterior diameters. The aortic arch was small and on the left side. At fluoroscopy, rapid feeble pulsations of the right cardiac border as compared with less rapid, fuller pulsations on the left were noted. Enlargements of the right atrium and possibly of the left ventricle were noted. The electrocardiogram showed on different occasions in addition to a right bundle branch block, either first or second degree A-V conduction delay.

On 10-24-57, the patient developed an area of fluctuation which extended from the medial mid-thigh region to the knee. This was incised on 10-30-57 and was found to contain a thin, purulent material. All antibiotics were discontinued on 11-15-57, and the patient was released on 12-3-57.

The patient did not return to the heart clinic, as she had been requested. About the first of May, 1958, she began to develop swelling of her legs and abdomen. She also developed severe dyspnea.

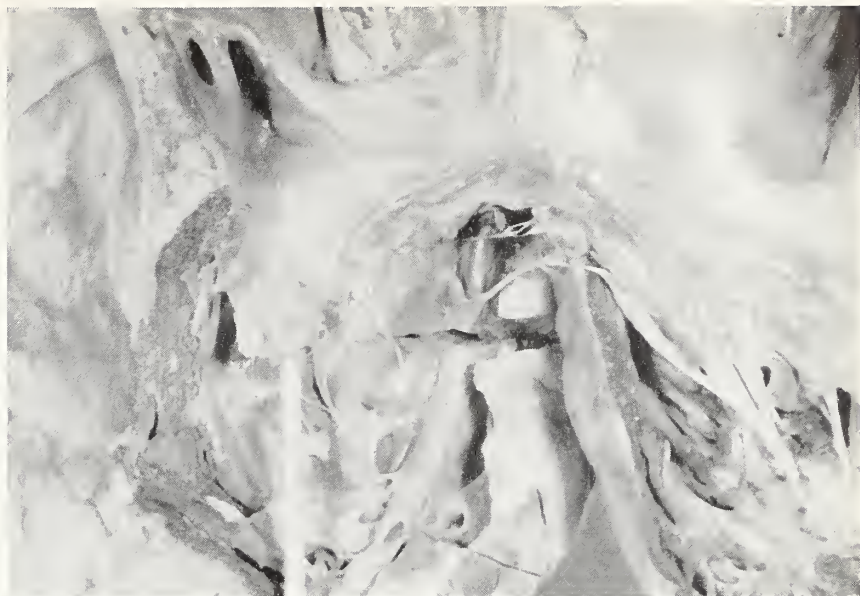
Physical examination on admission on 5-19-58 revealed a blood pressure of 110/60, pulse of 78, temperature of 98.6° and a respiratory rate of 40. Cyanosis of the lips and fingers was again noted. Decreased breath sounds and fine rales were heard over the left hemithorax. The abdomen was distended. The liver margin was palpable 7 cm inferior to the right costal margin. Moderately severe sacral edema, and severe edema of the lower extremities were present. The patient's hematocrit on this admission was 54% : hemoglobin was 17.4 gms. A fasting blood sugar was 80 mg per 100 ml of blood.

The patient was treated with digitalis and diuretics, with a loss of weight of approximately two pounds a day. A phlebotomy with removal of 500 ml of blood was performed. The patient was released on 6-25-58, to be re-admitted on 11-4-59 in a terminal condition. Her blood pressure was 90/60, her pulse was 50, and her respiratory rate was 32. She was markedly cyanotic. The lower margin of the liver was down 7 cm. She was given vasopressors intravenously, but died very shortly after admission.

Autopsy Findings

The heart weighed 350 gms. The right auricular appendage was markedly dilated, measuring 6 cm in diameter. Coronary arteries were free of arteriosclerosis. On opening the heart, the right atrium was found to be quite dilated. There was a large interatrial septal defect measuring 5 cm in diameter. A thin, semilunar shaped membrane extended out over the defect from the anterior margin for a distance of up to 2 cm. Several fenestrations measuring up to .5 cm in diameter were present along the line of attachment of this membrane. The tricuspid valve ring measured 12 cm in circumference. Leaflets measured at the most 1.5 to 2 cm in length.

FIGURE 6
CLOSEUP VIEW of septal leaflet and of a portion of posterior leaflet of the tricuspid valve. The applicator stick extends behind the free margin of the septal leaflet.



There was moderate fibrous thickening of the endocardium of the right ventricle. The right ventricle measured .2 cm to .3 cm thick. The pulmonic valve ring measured 6 cm in circumference. Several small fenestrations were present in the pulmonic valve cusps. The mitral valve ring was 10 cm in circumference but the mitral valve itself was not unusual. There was some calcification in the endocardium over the anterior papillary muscle and also calcification in the endocardium over some of the neighboring trabeculae carneae. The endocardium lining the left ventricle was slightly thickened. The left ventricle measured .6 cm thick. The aortic valve ring measured 5.5 cm in circumference. The aortic valve was normal, and the aortic arch was not remarkable. An anomalous artery arising between the left common carotid and the left subclavian artery was present.

Sections were taken through the mid portion of each tricuspid valve leaflet. Posterior and medial leaflets were adherent to the underlying endocardium of the right ventricle; the anterior leaflet was not adherent. The medial leaflet was the most involved, being adherent for a distance slightly over 1 cm, the posterior leaflet was adherent for a distance of slightly over .5 cm.

Both lungs together weighed 710 gms. They were subcrepitant throughout. There was an infarct measuring 3 cm in diameter in the lower lobe of the right lung. Both lungs were somewhat edematous and congested. A few small

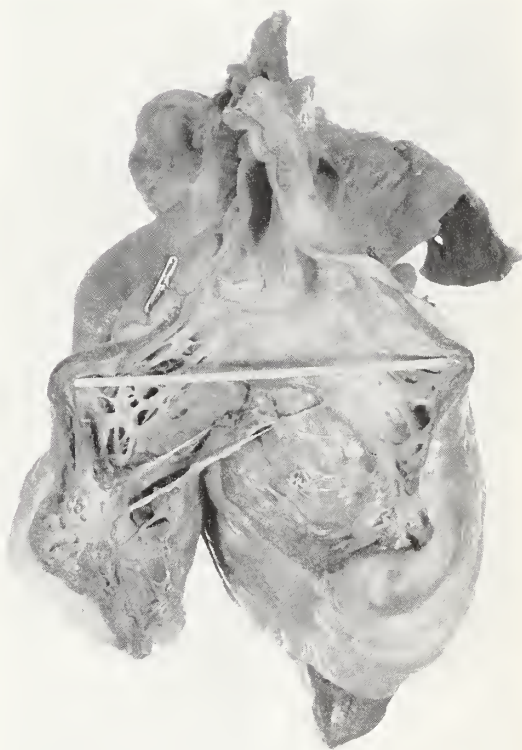


FIGURE 7
THE RIGHT VENTRICLE and the proximal portion of the pulmonary artery. There is slight endocardial fibrosis.

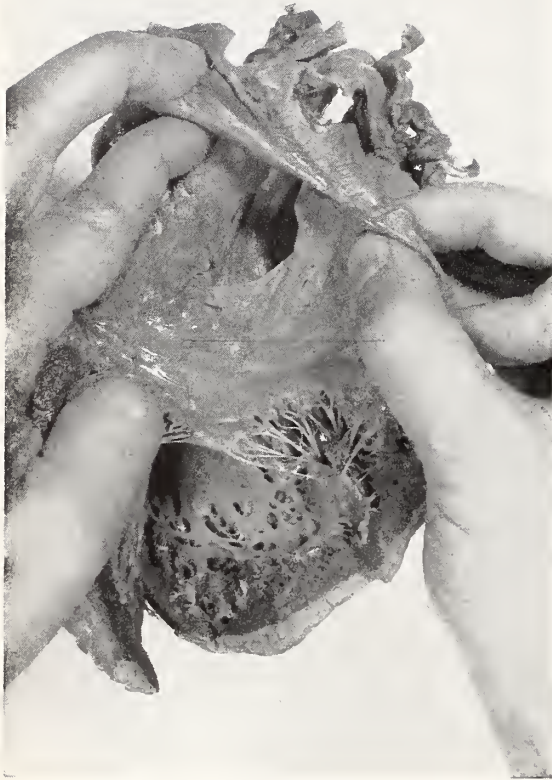


FIGURE 8
INTERIOR OF THE left atrium and the left ventricle, again
 shawing the interatrial septal defect.



FIGURE 9
THE INTERIOR of the left ventricle and of the proximal
 part of the ascending aorta. There is some subendocardial
 thickening, with calcification aver the papillary muscle and
 in the neighboring region.



FIGURE 10
PHOTOMICROGRAPH OF
BASE of anterior leaflet of
 tricuspid valve. Note arigin
 at annulus fibrosus, with
 atrial myocardium to the
 right in the picture and ven-
 tricular myocardium to the
 left.

FIGURE 11
THE BASE OF the posterior leaflet of the tricuspid valve arising from the wall of the right ventricle, well below the annulus fibrosus.



FIGURE 12
THE BASE OF THE medial or septal leaflet of the tricuspid valve arising from the wall of the right ventricle. The annulus fibrosus was too far removed to be included in this photomicrograph. Interstitial fibrosis throughout the myocardium is evident.



scattered hemorrhages were present. Some emphysema was also present. Small areas of interstitial fibrosis appeared in some areas.

The peritoneal cavity contained 1000 ml of clear straw-colored fluid and the pericardial sac contained 400 ml of clear straw-colored fluid. The liver weighed 1320 gms. The sinusoids were moderately congested, especially around the central veins. Parenchymal cells around the central veins were atrophic. The spleen weighed 400 gms. Splenic sinuses were congested. The right kidney weighed 180 gms and the left kidney, 170 gms. Both kidneys were moderately congested and showed slight chronic pyelone-

phritis and slight arteriolar-nephrosclerosis. The pancreas weighed 130 gms. It was normal grossly; microscopically, there was an increase in fibrous connective tissue around the pancreatic ducts. Trabeculae of this connective tissue extended out into the surrounding pancreatic tissue.

Altered Blood in Stomach

A small amount of altered blood was present in the patient's stomach. An ulcer .7 cm in diameter was present in the prepyloric region of the stomach. Two ulcers, each measuring 1 cm in diameter, were present in the first portion of the duodenum. One of these was adherent by

fibrinous adhesions to the under surface of the liver near the region of the gallbladder. Apparently this ulcer had perforated, but then became sealed off by the fibrinous adhesions.

Each adrenal weighed 6 gms. There was some lipid depletion in the cortex of each adrenal. The thyroid weighed 16 gms and was normal. The brain and pituitary were not remarkable. There was minimal arteriosclerosis of the aorta. The uterus and fallopian tubes had been removed surgically. One ovary containing a few corpora albicantia was present. The uterus and urinary bladder were normal. The gallbladder and extra hepatic bile ducts were normal.

Discussion

This case was clinically quite characteristic of Ebstein's anomaly. The patient was cyanotic since birth as are most patients with Ebstein's disease. This is explained by the interatrial septal defect or at least by the patent foramen ovale which so often accompanies this malformation, coupled with the increased pressure in the right side of the heart, producing a right to left shunt. As the patient gets older, the pulmonary vascular tree expands, decreasing the resistance on the right side so that a left to right shunt develops. The cyanosis disappears during this time. With age the lesion becomes more severe, or right sided heart failure develops, then the right to left shunt occurs again and the patient once more becomes cyanotic.

It is surprising, however, that a patient with Ebstein's anomaly who is cyanotic and who has a markedly enlarged heart will often have very few subjective symptoms, and will actually be able to perform fairly severe manual labor. Congestive heart failure does eventually occur in most of these patients. Death not infrequently results from the congestive heart failure. These patients also die as a result of cardiac arrhythmias which sometimes develop. A third cause of death reported occasionally is that of paradoxical embolus.⁴

Most of the other physical findings in this case were also typical. The engorged jugular veins and the enlarged liver, signs of right-sided heart failure, are often seen. There may or may not be pulsations felt in the liver or seen in the jugular veins, depending on whether or not the tricuspid valves are competent or not. Clubbed fingers are seen in one-third of the cases.¹ Mod-

erately low blood pressure is also characteristic.

Physical findings pertaining to the heart were not completely typical. The quiet precordium was indicative of a small right ventricle, and is characteristic. A split second sound was heard at the base of the heart. A diastolic third sound was also heard. These are also typical findings. However, no murmurs were heard. A soft diastolic murmur along the left sternal border, as well as a soft systolic murmur, are almost always present.³

X-rays in this case were quite characteristic. The large "box like" heart, small aortic shadow and clear lung fields with diminished vascular markings are almost diagnostic of this condition. The "box like" configuration of the heart is due to the enlarged right atrium. The right ventricle in Ebstein's anomaly is small. Ebstein's anomaly should be seriously considered in any patient with cyanotic congenital heart disease with a small right ventricle.⁴

The electrocardiogram in this case was suggestive of Ebstein's anomaly, although it was not entirely characteristic. Some degree of right bundle branch block is often seen, as was the case here. The P waves over the precordial leads are usually peaked, which was not the case here. Low voltage is the usual finding and was present in this patient. Up to one third of the patients in some series have been reported with the Wolf-Parkinson-White syndrome in the electrocardiogram. A patient with cyanosis and with the Wolf-Parkinson-White syndrome should be suspected of having Ebstein's anomaly, although other forms of congenital heart disease, such as transposition of the great vessels, have been reported with these findings also.

Cardiac Catheterization Aids Diagnosis

Cardiac catheterization was not performed on this patient because the diagnosis was apparent from the symptoms, physical findings, x-rays, and from the electrocardiographic findings. There have been some deaths reported from cardiac catheterization in these patients. These were due to the development of arrhythmias during the procedure. However, several fairly large series of cases have been reported in which the procedure, carried out under local anesthesia, did not meet with any bad results.¹⁻⁴ When the other findings are equivocal, cardiac catheteriza-

tion can at times be the only method by which the diagnosis can be established.

Recently, several authors have written about a procedure using cardiac catheterization in which intracavitary pressure and an intracavitary electrocardiogram are recorded at the same point.⁵ In Ebstein's anomaly, as the right ventricle is entered, atrial pressures will be recorded but a ventricular pattern will be seen on the simultaneously recorded electrocardiogram. This is because the elongated, adherent leaflets found in this condition convert much of the right ventricle functionally into the right atrium, giving the atrial pressure. The myocardium still present in the wall beneath the tricuspid valves behaves like right ventricle in the electrocardiogram.

Pathologically, the heart in Ebstein's anomaly usually presents a markedly enlarged right atrium, a small right ventricle and a left atrium and left ventricle of normal size. An interatrial septal defect is usually present. This may be simply a slit-like opening in the foramen ovale or it may be a large defect such as was seen in this case.⁶ Tricuspid valves are usually greatly elongated, often extending almost to the tip of the right atrium. Leaflets arise from the wall of the right ventricle, rather than from the annulus fibrosus between the ventricle and the atrium. The posterior leaflet is usually the most involved, arising at a point midway between the annulus fibrosus and the tip of the right ventricle.⁷ Attachments even closer to the apex of the right ventricle are not uncommon. The septal or medial leaflet is usually involved somewhat less, while the anterior leaflet is often completely spared. The elongated, tricuspid valve leaflets, as well as the displaced line or origin of the leaflets, converts a greater or lesser amount of the right ventricle into a functional right atrium.⁸

The myocardium beneath the adherent valves becomes quite thin and is partially replaced by fibrous connective tissue. This accounts for the partial or complete bundle branch block that is seen in the electrocardiogram. The enlarged right atrium, resulting from the interatrial septal defect and from the defective tricuspid valve account for the enlarged P waves that are usually seen in this condition.

Pathologic findings in this case were not entirely typical. In this particular case, the medial

leaflet was the most involved rather than the posterior leaflet. The medial and posterior leaflets, while arising from the wall of the right ventricle, did not arise nearly as far down on the wall as is so often the case. The slight fibrous thickening of the endocardium in this case as well as the calcification in the left ventricle can perhaps best be explained as being the result of the moderate anoxia which the patient had for so many years.

Summary

A case of Ebstein's anomaly is presented. These cases can be diagnosed clinically by the following findings:

1. Cyanosis, right sided heart failure and an inactive precordium.
2. Duplication of the second heart sound heard along left sternal border at the base of the heart, with a third heart sound often present. A systolic murmur, a diastolic murmur, or both are almost always present.
3. "Box like" configuration of the heart by x-ray, with a small aortic shadow and normal or decreased vascularity in the lung fields.
4. Low voltage in the electrocardiogram, peaked P waves in the precordial leads, some degree of right bundle branch block. (About one third of the patients have the Wolf-Parkinson-White syndrome).
5. Cardiac catheterization and intracardiac electrocardiography if necessary.

This case was not entirely typical in that a murmur was not present. Pathologically, it was not entirely typical in that the downward displacement of the tricuspid valve ring was not as great as is usually seen.

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Wounds and Disease in the Confederate Army

Confederate forces actively engaged in the four years' War Between the States numbered no more than 600,000 troops. This small force faced a total number of 2,800,000 soldiers mustered as volunteers and through the world's first military draft, into the Union Army, or approximately four times the fighting contingent of the Confederate States. Of the 600,000 Confederate troops 54,000 were killed outright and approximately 200,000 died either from battle wounds or from disease. Another 200,000 were lost to the Confederate States Army as prisoners of war because of the policy of non-exchange of prisoners adopted and enforced by the United States. Another 100,000 were discharged because of disability from wounds or disease or actually deserted during the war years.

Within this small and horribly decimated force, approximately 3,000,000 cases of wounds and disease were cared for by the Medical Corps of the Confederate States Army. On an average, then, each Confederate soldier was disabled by wounds and sickness about six times during the war. On April 9, 1865, as the war ended at Appomattox, General Lee could not muster 10,000 men who were fit for active warfare from his former great Army of Northern Virginia; Dick Ewell surrendered at Sailor's Creek with only 8,000 men to Phil Sheridan.—R. B. Stark, M.D.: *Surgeons and Surgical Care of the Confederate States Army. Va. M. Monthly*, May 6, 1960; *Ill. Med. J.*, Oct., 1960.

Marfan's Syndrome:

Report of a Case with a Congenital Aneurysm of the Coronary Sinus and Perforation Into the Right Ventricle

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CONGENITAL ANEURYSMS of the coronary sinuses are rare. Currently, 78 cases have been collected from the literature since the original description by James Hope in 1839.⁶ Widespread use of cardiac catheterization and angiocardiology has made premortem diagnoses considerably easier. Successful surgical correction of these defects has attached more importance to premortem diagnoses. Following is an account of a case studied at necropsy.

Case Report

A 31-year-old white male was admitted to a hospital January, 1959, following incidental finding of a confluent haziness and a cavity in the left lower lung field. Cultures of gastric washings were obtained and myobacterium tuberculosis was identified. At this time the patient gave no history of cardiac pain and only noted slight dyspnea after extra exertion. He had been hospitalized at age seven for empyema and drainage of the left lung. At age 20 he was admitted for one month to a tuberculosis sanatorium, and was thereafter rejected from military service apparently due to a skeletal deformity. No mention was made of possible heart disease until age 29.

Physical examination in January, 1959, showed a pulse rate of 85; systolic blood pressure was 120 mm Hg and diastolic pressure, 90 mm Hg. Skeletal abnormalities included a kyphotic spine, pigeon breast deformity and fingernail clubbing. The left lower chest was

dull to percussion and breath sounds were decreased. A loud systolic-diastolic murmur was heard along the left sternal border. It was associated with a thrill in the pulmonic area. Bilateral inguinal hernias were noted. One examiner described bilateral dislocated lenses.

Arteries Enlarged

Chest fluoroscopy revealed enlargement of aortic and pulmonic artery shadows. Pulmonary vascular markings were increased. Cardiac catheterization studies indicated a left to right cardiac shunt. Oxygen saturation of the right ventricle was 56% and the main pulmonary artery, 61%. Pulmonary artery pressure and the calculated vascular resistance were normal at rest.

The patient was started on antituberculosis drugs and later underwent left thoracoplasty. After recovery he was discharged from the hospital. In April, 1959 he was readmitted to a tuberculosis sanatorium. In July, 1959, following a temporary increase in activity, he developed periphreal edema, cyanosis and pulmonary congestion. The patient received digitalis and mercurial diuretics with a subsequent loss of 20 lbs. He remained stable until January, 1960 when mercurial diuretics were again required. By March, 1960, the patient had become dyspneic and edematous at rest. He died March 30, 1960.

Necropsy Findings

At necropsy the patient had a flattened left chest cage, pigeon breast deformity and a kyphotic spine. Peripheral edema was present.

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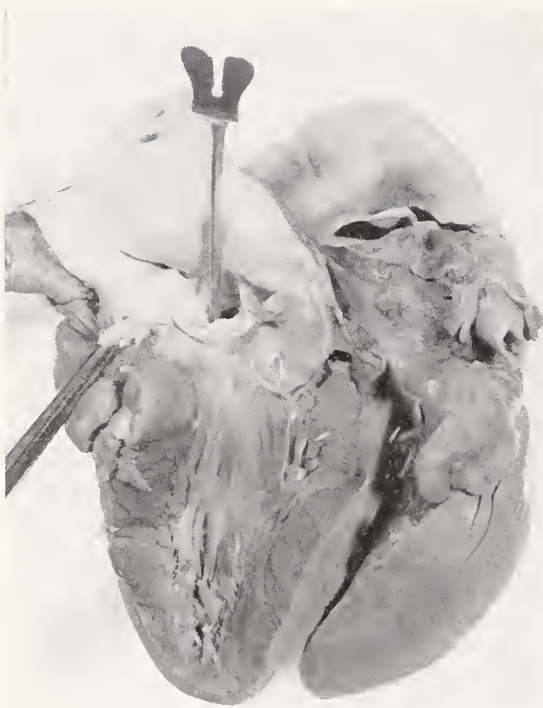


FIGURE 1
VIEW OF LEFT VENTRICLE and aorta: A probe has been inserted into the ostia of the right coronary sinus aneurysm.

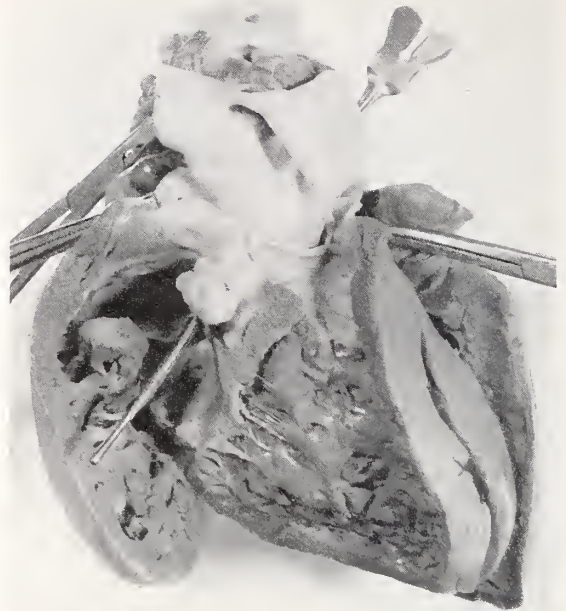


FIGURE 2
VIEW OF RIGHT VENTRICLE: The cone-shaped aneurysm is seen projecting into the right ventricle just below the pulmonic valve. A probe has been inserted along the fistula tract.



FIGURE 3
MICROSCOPIC cross-section of the aneurysm.

The right thoracic cavity contained 500 cc amber-colored fluid and the pericardial sac, 30 cc of similar fluid. His left lung was densely adherent to the chest cage and atelectatic and the right lung was edematous. Heart weight was 470 gms and the valve measurements were as follows: mitral, 11 cm; tricuspid, 12.5 cm; aortic and pulmonic, 7.5 cm. The left ventricular wall muscle was hypertrophied and the right ventricle was dilated. An aneurysmal fistula was located between the base of the right coronary sinus and the right ventricle. (Figures 1 and 2) The aortic ostia measured 6 mm and the right ventricle ostia, 3 mm. The aneurysm projected into the cavity of the right ventricle, approximately 3 mm below the pulmonic valve ring.

Microscopic sections showed the aneurysm was lined with endothelium on two surfaces with an intervening connective tissue layer. (Figure 3) Sinuses of the liver and spleen were congested with red cells and indicated severe passive congestion. Alveoli of the right lung showed capillary congestion and edema in the alveolar spaces.

Discussion

Rupture of coronary sinus aneurysms are due to endocarditis of the aortic valve, chronic syphilis and a developmental defect in the aortic media at the coronary sinus level.^{2,3,14,15} Congenital variety is the most frequent.

The aorta following its origin from the truncus arteriosus rotates to a posterior position to enter the left ventricle. The right margin of the aortic or distal bulbar septum fuses with the ventricular septum.² This is later represented as the area of fusion of the annulus fibrosa and the aortic elastic media. Edwards and Burchell have shown that the congenital defect is due to a lack of continuity between the aortic elastic media and the annulus fibrosa³.

Stress of aortic pulsation appears to initiate the aneurysmal formation. Due to the essentially intracardiac position of the sinuses, aneurysms tend to burrow through the adjacent cardiac muscle.² The right coronary sinus, for example, lies adjacent to the right atrium and the outflow tract of the right ventricle. Aneurysms of this sinus therefore tend to project into these cavities. The left coronary sinus is external to the right ventricle and lies within the pericardial sac, while the noncoronary sinus lies adjacent to the right atrium.⁶

In our case the aneurysm originated in the right coronary sinus, projected into the right ventricle just below the pulmonic valve ring and then perforated at the apex of the sac. This is often the situation. The ostia have averaged 0.4 to 3.6 cm in diameter and the fistulas, lined with endothelium.⁵ The aneurysms are cone-shaped, membranous and are generally perforated at the apex of the cone. The aortic media does not participate in the aneurysmal wall formation.³

In one series of 55 cases the right coronary sinus was the site of origin of the aneurysm in 42 instances, the noncoronary sinus in 19 cases and the left coronary sinus in two cases.⁶ Terminus of the right coronary sinus aneurysm is usually right ventricle, while terminus of the noncoronary sinus aneurysm is generally the right atrium. The pericardial sac, the pulmonary artery and the left ventricle are very unusual terminal sites.¹⁵ etc. The left ventricle is often hypertrophied.^{3,17} Bicuspid aortic valves, ventricular septal defect, coarctation of the aorta

and Marfan's syndrome have been noted as associated lesions.⁸⁻¹¹

Secondary Evidence Reveals Syndrome

Several sections of the ascending aorta failed to show the definite pattern of cystic medial necrosis. However in view of the secondary evidence of a mesothelial developmental defect, we believe that Marfan's syndrome was present in our case.

Cases studied by cardiac catheterization have shown that the higher aortic pressure serves to shunt blood into the pulmonic circulation.¹² As might be anticipated the pulmonic circulation is overloaded and arterialized. Pulmonic artery pressure and oxygen saturation are generally increased.^{7,16} Left ventricular output is increased with an aortic runoff comparable to aortic regurgitation and a subsequent decreased systemic flow occurs.¹⁴ The aortic valve itself may be incompetent. Of interest, the cardiac muscle through which the fistula travels likely acts as a sphincter to reduce the flow during systole but allows a free flow during diastole.¹²

The clinical course in this case is somewhat atypical. Only 30% of the described cases have had such an insidious onset.⁶ Typically the onset of rupture can be dated to the acute occurrence of precordial or epigastric pain, both of which rarely radiate into the arms or elsewhere. A lesser number can be dated to the acute onset of dyspnea and palpitation after some unusual effort. After a few hours, an asymptomatic phase supervenes and lasts for months or years. Thereafter, patients have developed cardiac failure or bacterial endocarditis. Cardiac failure has been characteristically progressive.^{5,6} The heart appears to tolerate congenital fistulas better than those that have occurred secondary to rupture of an aneurysm in later life.⁴ A smaller number have been diagnosed prior to rupture.⁸⁻¹⁰

Physical findings are similar to those described in this case; a loud continuous systolic-diastolic murmur, a systolic thrill, signs of tricuspid insufficiency and a wide pulse pressure.¹ The electrocardiographic findings have included normal tracings, left ventricular hypertrophy, right bundle branch block and complete heart block.

Due to the intracardiac position of the sinuses, conventional x-rays have not been specific. The right atrium and ventricle may be dilated. The ascending aorta may be enlarged and generally

the pulmonary vascular shadows are increased and pulsatile.^{5, 6, 8-10} Venous angiocardiology or retrograde aortography allows an accurate diagnosis to be made.^{7, 8-11, 17}

Surgical Procedures

Since 1957 several cases have been operated upon. The surgical closure has included direct suturing of the defect and the insertion of a plastic prosthesis in the fistula.^{7, 14, 16} Open heart surgery is employed. Although the occasional case has survived for many years after rupture the hazard of either intractable congestive failure or superimposed bacterial endocarditis always exists. Thus surgical closure is indicated in most cases after rupture has occurred.

Summary

Necropsy findings of a ruptured right coronary sinus aneurysm communicating with the right ventricle have been discussed. A review of the embryological, pathogenic, clinical and therapeutic aspects of congenital aortic sinus aneurysm is presented.

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Anatomic Variations of the Coronary Arteries And Their Clinical Significance

The third reported case
of an unusual anomaly.

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VARIATIONS in the origin of one or both coronary arteries are rare and are usually discovered as incidental autopsy findings. Gradually recognition of the serious clinical significance of certain of these anomalies, even when not associated with congenital defects of the heart and great vessels, has evolved.

Occasionally these variations include the origin of a coronary artery from an unusual site within the aorta or one of its branches. The two arteries supplying the heart may originate from the aorta as a common trunk. Rarely both coronary arteries are discovered to arise from the pulmonary artery. One rare lesion, but the most frequently encountered anomaly of this sort, is the condition in which the left coronary arises from the pulmonary trunk while the right coronary artery takes origin from the aorta. This condition is often fatal in infants; however, some individuals with this anomaly have survived to adulthood.

There have been two previous reports^{1,2} of an anatomic variation in which this situation is reversed: the left coronary artery arises from the usual site in the aorta while the right coronary springs from the pulmonary trunk. This report concerns such an individual in whom the condition was discovered incidentally at autopsy.

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Case Report

A 55-year-old Negro female sought treatment at Marion County General Hospital in September, 1955, for the complaints of a choking sensation aggravated by lying down, shortness of breath precipitated by exertion and chest pain which was also associated with exertion and radiated into the left arm. She reported that 15 years previously she had experienced an illness diagnosed as rheumatic fever and characterized by pain of considerable severity in the joints of the lower extremities.

Physical examination disclosed the blood pressure to be 155/95. A grade III, systolic murmur was heard at the aortic valvular area. This murmur radiated into the neck and was associated with a palpable thrill at this area. A grade II, diastolic murmur was heard at the left sternal border. An electrocardiogram was interpreted as showing occasional auricular premature systoles and non-specific ST-T wave changes. The patient received the usual regimen for congestive heart failure from which she obtained some relief of symptoms. In addition, pentaerythritol tetranitrate tablets were prescribed for control of the chest pain.

The patient was examined periodically during the next three years with little change in the clinical findings. Angina pectoris continued to be a prominent feature of her illness. Fluoro-

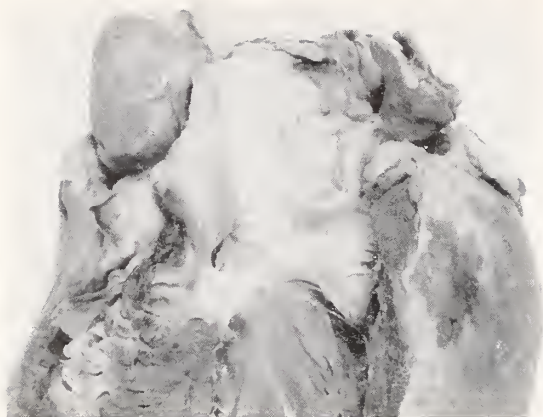


FIGURE 1
VIEW OF THE aortic valve. The left coronary artery has been opened; Ostium is visible to the left of the margin of the valve.



FIGURE 2
VIEW OF THE pulmonary valve. The arigin of the artery is 1.5 cm above the valve; opening is visible just below the cut edge of the ortery.

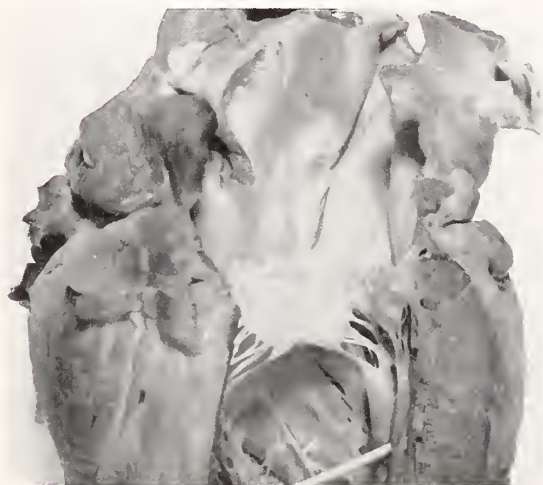


FIGURE 3
THE MITRAL VALVE. An adhesion between the leaves is present. The chordae tendineae are thickened and shortened. There is thickening and fibrosis of the wall of the left ventricle.

scopy revealed enlargement of the left atrium, left ventricle and right ventricle.

Discontinues Medication

The patient developed signs of acute congestive failure when she voluntarily discontinued her medications. She was admitted to this hospital Sept. 2, 1960. At this time the blood pressure was 160/100; the pulse rate was 88 per minute and was irregular. Neck veins were distended. The murmurs had not changed in character. White blood cell count was 6,300 per cubic mm, hemoglobin 12.8 gm %, blood sugar 84 mg % and blood urea nitrogen, 7 mg %. X-rays of the chest disclosed cardiac enlargement with a

trans-cardiac diameter of 18.5 cm compared to a trans-thoracic diameter of 25.4 cm. An electrocardiogram at this time revealed features of left ventricular hypertrophy.

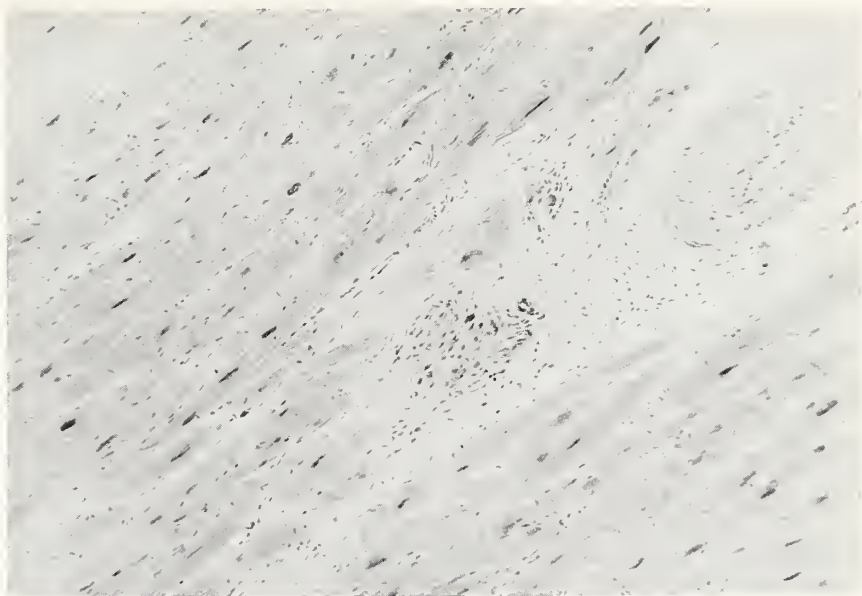
After initial improvement following reinstitution of a congestive failure regimen, the patient developed intermittent episodes of auricular fibrillation. She died suddenly Sept. 14, 1960.

Autopsy Findings

At autopsy 200 cc of clear, straw-colored fluid were encountered in each of the hemithoraces. The pericardial sac and the epicardial surface of the heart were smooth and glistening except a small area posteriorly at the apex and the postero-lateral margin of the right ventricle. In these areas there were dense adhesions between the two surfaces. Weight of the heart was 600 gm. The leaves of the tricuspid and pulmonary valves were thin and translucent. The leaves of the mitral valve were slightly more opaque than normal. There was one adhesion between the anterior and posterior leaves with an 0.4 cm calcified, verrucous excrescence at this point. The valve was not markedly stenotic, and line of closure measured 8 cm in circumference. Chordae tendineae were very slightly thickened and shortened; papillary muscles were not remarkable; aortic valve cusps were also thickened, but there were no adhesions. There was some calcification at the base of the valve. The right ventricular wall was 0.4 cm thick; left ventricular wall was 1.4 cm thick; the endocardial surface was not remarkable.

There was slight, intimal arteriosclerosis of

FIGURE 4
SECTION OF MYOCARDIUM showing the presence of an Aschoff nodule at one pole of a vessel. There is focal fibrosis of the myocardium.



the coronary arteries. The left coronary artery originated behind the left cusp of the aortic valve, and the right coronary artery arose 1.5 cm above the pulmonary valve. The arteries were found in the usual anatomic distribution and no gross anastomoses between the two arteries were discerned. The myocardium was red-brown in color. Interestingly, the innominate and common carotid arteries sprang from the arch of the aorta as a common trunk.

Microscopically there was slight focal fibrosis of the myocardium of both the right and left ventricles. An occasional Aschoff nodule was encountered within the heart muscle and were somewhat more prominent in sections of the mitral valve.

The remainder of the examination revealed pulmonary edema and congestion. A few patchy areas of bronchopneumonia were present. There was slight, chronic pyelonephritis within the kidneys. Passive congestion of the liver and spleen and interstitial fibrosis of the pancreas indicated previous bouts of congestive-heart failure.

Discussion

In the two previously reported cases, the condition was thought to have had no bearing on the patients' deaths. The first case reported in the literature was that of a 30-year-old male who died of a subdural hematoma sustained during an epileptic seizure. The second, one of a 61-

year-old laborer who died of auricular fibrillation and congestive heart failure. At autopsy cardiovascular lues, insufficiency of the aortic valve cusps and aneurysmal dilatation of the ascending aorta were found.³

In the case reported here, the condition is felt to have contributed to the patient's death. In this instance the heart had been previously involved with rheumatic heart disease. Minimal mitral stenosis was found at autopsy. Angina pectoris had been a prominent, clinical feature throughout the patient's illness; no occlusive disease was found to account for this symptom which has its pathologic basis in an ischemic myocardium. Ischemic changes within the myocardium were discovered microscopically. These changes are attributed to an inadequate supply of oxygen by an anomalous right coronary artery to a myocardium overburdened with rheumatic involvement.

A number of instances are reported in which individuals with a left coronary artery arising from the pulmonary artery have survived into adulthood, but this particular anomaly is usually encountered in infants who die within the first year of life. In the third to fifth month of life, such an infant develops tachycardia, respiratory wheezing and difficulty in feeding with frequent regurgitation. Bouts of colicky pain, profuse sweating and peripheral cyanosis associated with or immediately following feeding may be observed. The electrocardiographic changes are

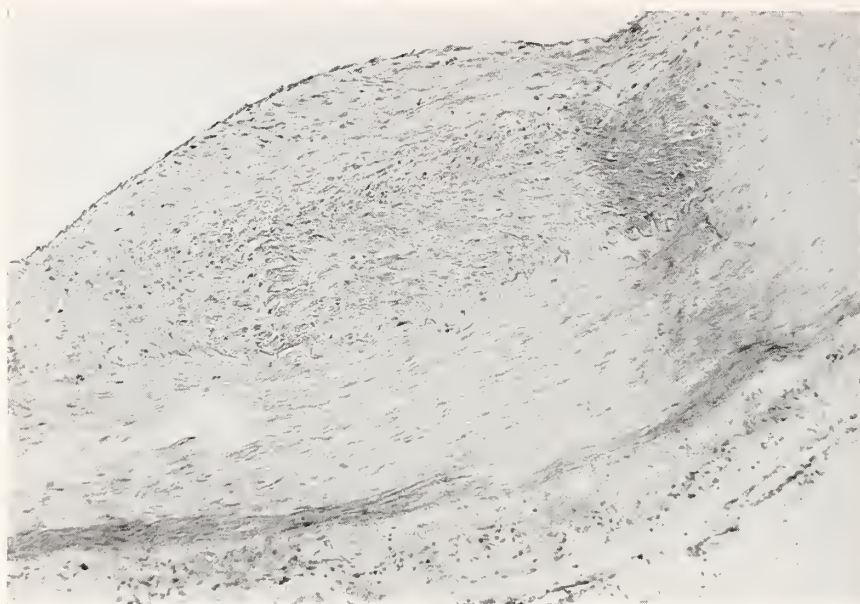


FIGURE 5
WALL of the left coronary artery. There is slight intimal arteriosclerosis.

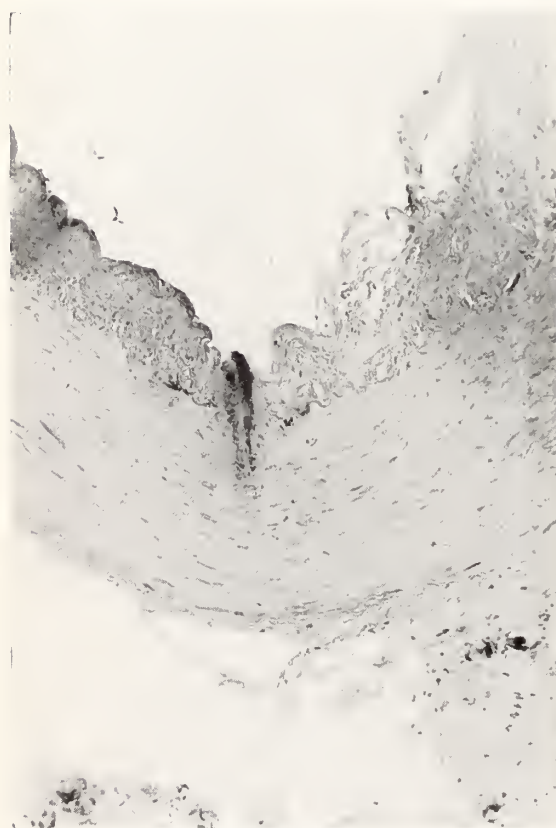


FIGURE 6
PHOTOMICROGRAPH of the right coronary artery. The media is well developed.

those of left ventricular hypertrophy with coronary-type T wave changes. Deep, significant Q waves are often present in leads I, AVL and the left precordial leads. If extensive subendothelial changes are present, the electrocardiogram of fibroelastosis may be simulated.⁴

The aberrant artery is usually thin-walled and is often described as vein-like in character. Histologically the vessel is arterial in structure, although thinning of the media may be evident. Frequently there is thinning and scarring in that portion of the left ventricular wall supplied by the displaced left coronary artery; the entire left ventricle or simply the involved portion may be dilated. However, aneurysm formation is rare. Hypertrophy of other parts of the heart muscle is present. In infants the formation of elastic tissue and scarring tends to be toward the endocardial surface. Calcification may occur. The area may be the site of an infarct, and mural thrombi may be present.⁵

Few Undergo Surgery

Surgical approaches to this problem have been limited to a few cases. In these individuals attempts have been made to create a stenosis of the pulmonary artery beyond the origin of the

aberrant left coronary.⁵ The aim is to increase the pressure within the left coronary artery and create a more adequate supply of unoxygenated blood to the involved part of the left ventricle. This is feasible since, in the cyanotic forms of congenital heart conditions, the vascular bed of the heart compensates for low oxygen content of the blood by dilatation. Coronary insufficiency is rare in congenital heart disease.⁶

In adults in whom the left coronary arose from the pulmonary, coronary arteries were dilated and tortuous. Anastomoses were present between the left and right coronary arteries. It has been suggested that the left may simply function as a vein and not as an artery supplying unoxygenated blood from the pulmonary trunk to the myocardium.⁷ Hence, an arteriovenous fistula is created with oxygenated blood being supplied from the right coronary artery; this blood upon entering the left coronary artery follows a course of least resistance and flows into the pulmonary artery.⁸

Anomalies and Variations

In the embryo the coronary arteries arise as buds from the endothelial surface of the bulbus arteriosus about the 12th to 14th day of embryonic life. The left bud is formed first; the right makes its appearance a short time later. The anlage grows out as a solid mass of cells and later acquires a lumen. Anomalies may be explained by a faulty arrangement of the endothelial buds. Another explanation is that of a faulty arrangement of the spiral septum which forms to separate the truncus communis into the aorta and the pulmonary artery.⁹

Other variations in the origins of the coronary arteries have been reported. True anomalies are not associated with extensive developmental defects of the heart or great vessels. Minor variations include the origin of the arteries from a higher level of the aorta: one of the coronary arteries has been discovered to arise from the arch of the aorta, the innominate artery or from a carotid artery.

Occasionally a single coronary artery may originate from the aorta. This trunk usually divides into two major branches, right and left. This arrangement is almost never responsible

for myocardial ischemia, cardiac enlargement or electrocardiographic changes. In the absence of other cardiac abnormalities such patients have a normal life span.¹⁰ There are two case reports of individuals in whom both the left and right coronary arteries arose from the pulmonary artery. This arrangement is incompatible with life.

Summary

A case is presented in which a very unusual anatomic variant of the origin of the right coronary artery existed. The left coronary artery originated from the aorta; the right coronary arose from the pulmonary artery. Two previously reported cases are discussed. The relationship of this variant to the production of angina pectoris in a patient with rheumatic heart disease is examined.

ACKNOWLEDGMENT

The author wishes to express appreciation to the photographic laboratory at Marion County General Hospital, under the direction of Robert Albright, for the illustrations which accompany this article.

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Primary Cardiac Amyloidosis: A Case Report

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JTHOMASHOW, ANGLE and Morrione¹ in 1953 reported two cases of amyloidosis limited to the heart and one case of amyloidosis involving the heart, pulmonary vessels and alveolar walls. They proposed that such cases be classified as "Primary Cardiac Amyloidosis." This entity differs from primary amyloidosis in that it occurs in an older age group and that the extra-cardiac amyloid is either totally absent or present in insignificant amounts. Other terms that have been used to describe similar cases are: "atypical amyloidosis associated with senility,"² "cardiovascular amyloidosis,"³ and "amyloid localized to the heart."⁴

Case Report

A 64-year-old retired paper hanger was admitted to the Marion County General Hospital June 18, 1952 with a history of nausea of two weeks' duration and edema of the lower extremities for one week. The patient stated that for the preceding six years he had required two pillows beneath his head when reclining. At the age of 18 years he had contracted syphilis, and on two occasions he had been treated for gonorrhea. He had received treatment for syphilis but there was no information available as to the specific therapy. There had been two previous admissions to this hospital, for gunshot

wounds of the legs in 1936 and for a right hernioplasty in 1941.

On admission the blood pressure was 180/90 mm Hg, the pulse 100/min. with occasional premature contractions. The point of maximal impulse of the heart was in the fifth intercostal interspace, 2 cm lateral to the mid-clavicular line. There was 1-plus edema of the lower portions of both legs. The liver margin was palpable 3 cm inferior to the right costal margin.

Laboratory data included a hemoglobin of 11 gms per 100 ml of blood and a white blood cell count of 2,550 per mm.³ The urine had a specific gravity of 1.020, and was negative for albumin and sugar, but there were 8-10 white blood cells per high power field on microscopic examination. The Kline test was 4-plus and the Kahn test, 3-plus. A chest film was reported as "a hypertensive heart with bilateral congestive changes of a marked degree." An electrocardiogram was interpreted as non-specific S-T changes compatible with myocardial ischemia and an interventricular conduction defect. Treatment was symptomatic, consisting of oxygen therapy and bed rest. He improved rapidly and was released June 20, 1952. He was treated in the out-patient clinic and his therapy consisted of a low sodium diet, digi-toxin and injections of dicurin. He failed to keep any appointments after April 9, 1955.

Symptoms Recur

Dyspnea and severe swelling of his lower extremities again occurred and he was admitted

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to this hospital on August 29, 1955. There was 4-plus pitting edema of the lower extremities extending proximally to the mid-thigh region. Several weeping, ulcerated areas were present on the left lower leg. His blood pressure was 135/75 mm Hg.

An electrocardiogram was interpreted as showing a focal conduction disturbance, S-T wave changes compatible with diffuse myocardial disease, and the presence of Q-waves in V_1 and V_2 , suggesting an antero-septal infarction.

Cardiac fluoroscopy was performed Sept. 14, 1955 and revealed a generalized dilatation and tortuosity of the thoracic aorta without a demonstrable aneurysm. Since the patient was normotensive and had a positive serologic test for syphilis, the etiology of the heart disease was suggested to be related to lues. Digitoxin, dicurin, Ilotycin and penicillin were given to the patient. Burrow's solution soaks and lanolin were applied to the leg ulcers. A weight loss of 20 lbs. occurred as the patient improved. He was discharged from the hospital Sept. 15, 1955.

He made periodic visits to the out-patient clinic for injections of dicurin, and was maintained on digitoxin. Ascites and edema of the lower extremities developed and he was hospitalized on Nov. 4, 1956. Blood pressure at this time was 130/80 mm Hg. The heart rate was 84/min. and there was a gross irregularity. The heart was enlarged to the left and no murmurs were heard. Moist rales were heard in the bases of both lungs. An umbilical hernia was present. Urinalysis showed a specific gravity of 1.020, 1-plus albumin, and 4-6 wbc/hpf. He was given Dicumerol, dicurin, digitoxin and placed on a low sodium diet. There was a weight loss of 34 lbs. The patient was released from the hospital Dec. 13, 1956 with instructions to continue the digitoxin, and to return to the out-patient clinic.

Returns with Edema, Ulcers

Edema and ulcerations of the lower extremities caused the patient to return to the hospital March 4, 1957. On this admission blood pressure was 100/60 mm Hg. Pulse was 60/min. with an occasional premature contraction. A grade 1 apical systolic murmur was heard. The abdomen was protuberant and the liver margin was palpable 3 cm inferior to the right costal margin. There was 4-plus pitting edema of the lower

extremities, and several ulcerated areas were present. The hemoglobin was 9.5 gms per 100 ml blood, and the white blood cell count was 6,050 per mm.³ A protein-bound iodine was reported as 4.95 gamma percent. On one occasion the urine contained 2-plus albumin. The STS was still 4-plus, but the spinal fluid had a negative Wasserman reaction. He received 600,000 units of penicillin daily for 10 days. The leg ulcers were treated with boric acid soaks and topical bacitracin. His weight decreased from 222 to 184 lbs. Upon being discharged April 8, 1957, he was instructed to return to the out-patient clinic.

Right Bundle Branch Block

His next admission was July 27, 1957, and the complaints were again pain and swelling of the lower extremities. The heart was enlarged and there was a soft systolic murmur and auricular fibrillation. The liver was palpable 8 cm inferior to the right costal margin. Examination of the abdomen revealed shifting dullness and a fluid wave. Numerous ulcers were seen on the lower extremities. An electrocardiogram was interpreted as showing a right bundle branch block and auricular fibrillation. The blood urea nitrogen was 45 mg per 100 ml of blood. The STS was still positive. The total bilirubin was 1.6 mg, direct 0.85 mg and indirect 0.75 mg per 100 ml serum. He was treated with bed rest, digitoxin, and dicurin and his weight decreased from 213 lbs. to 190 lbs. Boric acid soaks and bacitracin ointment were applied to the legs. He was released from the hospital Aug. 12, 1957.

Dyspnea and lower extremity edema became severe and he was readmitted to the hospital Nov. 15, 1957. His blood pressure at this time was 105/70 mm Hg. The PMI was in the 6th intercostal interspace, 15 cm to the left of the midsternal line. A few basilar rales were heard. The abdomen was distended and the liver margin was palpable 10 cm inferior to the right costal margin. Lower extremities were edematous and several ulcers were present on the lower portions of the legs. An electrocardiogram was interpreted as showing a right bundle branch block and auricular fibrillation. A chest film revealed cardiomegaly, TCD 21.5 cm and TTD 32 cm, and widening of the aorta. In addition to the medication he had received previously he was also given penicillin and streptomycin on this admission. The leg ulcers began to heal and his



FIGURE 1
ROENTGENOGRAM of the chest, March, 1958. The heart is enlarged and there is an infarct in the left lung.

weight decreased from 208 to 188 lbs. He was discharged from the hospital Dec. 18, 1957.

Bloody Sputum Cough

He developed a cough productive of a bloody sputum in February, 1958 and he was admitted to the hospital on the 10th of that month. Blood pressure at that time was 90/50 mm Hg and his pulse was 60/min. and irregular. The PMI was in the 6th intercostal interspace in the anterior axillary line. Ascites and edema of the lower extremities were present. A chest film on Feb. 17, 1958 showed the heart to be enlarged and in the left lung field was an area that was thought to be an infarct or a pneumonia superimposed on an infarct. A repeat film on March 10, 1958 showed a persistence of this area (Figure 1).

The hemoglobin was 11.3 gms per 100 ml blood, and the white blood cell count was 7,050 mm^3 with a differential of polymorphonuclear leucocytes 74%, band forms three percent, metamyelocytes one percent, eosinophiles one percent, and lymphocytes 21%. Blood urea nitrogen was 90 mg per 100 ml of blood. The urine contained 4-6 wbc/hpf. The serum bilirubin on Feb. 13, 1958 was 9 mg per 100 ml of serum, with a direct of 6 mg and an indirect

of 3 mg. On Feb. 25, 1958 the bilirubin was 2.8 mg with a direct of 1.8 mg and an indirect of 1.0 mg. The alkaline phosphatase was 13 K. A. units, the total protein 6.7 gms per 100 ml plasma and the serum glutamic oxalacetic transaminase was 8 units. Sputums were collected on six consecutive days and all were negative on smear and culture for acid-fast bacilli. He was placed on a low sodium diet and given digitoxin, dicurin and diuril. He was released March 15, 1958.

Leg Abrasion

An abrasion of his right leg occurred in May, 1958, as a result of a fall, and subsequently ulceration developed. He was admitted to the hospital June 9, 1958. His blood pressure was 120/70 mm Hg and pulse 80/min. and irregular. A grade II systolic murmur was heard. There was 4-plus pitting edema of the lower extremities and a large ulcer on the right leg. The liver margin was palpable 6 cm inferior to the right costal margin. An abdominal paracentesis was performed July 10, 1958, with 1900 ml of straw-colored fluid removed. The specific gravity of the fluid was 1.019. Immediately following this procedure the blood pressure was 98/58 mm Hg. Treatment was essentially the same as on previous admissions and he left the hospital Aug. 4, 1958.

He returned to the hospital Nov. 4, 1958 with dyspnea, ascites and ulcers on the lower extremities. Blood pressure was 124/86 mm Hg and the pulse was 56/min. and irregular, but no pulse deficit was noted. The serum bilirubin was 0.7 mg per 100 ml, alkaline phosphate 8 K. A. units, cephalin flocculation was 3-plus at 24 hours and 4-plus at 48 hours. Blood urea nitrogen was 45 mg per 100 ml of blood. Abdominal paracentesis was performed on five separate occasions and a total of 9,900 ml of fluid was removed. On Nov. 28, 1958, there was a transient episode of right hemiparesis with almost complete recovery within 24 hours. This was thought to be due to transient focal ischemia. The treatment was similar to that given on previous admissions and he was discharged from the hospital Dec. 13, 1958.

Heart Shows Enlargement

His final admission was Feb. 3, 1959. He complained of edema of the lower extremities, dyspnea on exertion and orthopnea. He had

FIGURE 2
THE ABDOMEN is distended and the umbilical hernia is protruding. The thighs are edematous and superficial ulcerations are present.



not kept his appointments with the out-patient clinic and had not refilled his prescriptions after exhausting the supply given him upon his release from the hospital in December. Blood pressure was 124/78 mm Hg, pulse was 60/min. and regular. Rales were heard at the base of the right posterior chest. The cardiac border was not distinct but seemed to be enlarged. The liver was palpable 17 cm inferior to the right costal margin. His abdomen was distended with fluid and an umbilical hernia protruded an estimated 7 cm (Figure 2).

The external genitalia were very edematous. There was 4-plus pitting edema of the lower extremities with stasis dermatitis. Hemoglobin varied from 10.4 gms to 12 gms, and the white blood cell count from 4,500 mm^3 to 9,350 mm^3 . Specific gravity of the urine was 1.017, with 1-plus albumin and 10-12 wbc/hpf. In several roentgenograms of the chest the heart appeared substantially enlarged (Figure 3). An electrocardiogram showed a right bundle branch block, ventricular premature systoles and auricular fibrillation. The blood urea nitrogen on admission was 96 mg per 100 ml of blood. He was given diuril, digitoxin, Diamox and dicurin.

On Feb. 11, 1959, there was an episode of epistaxis and the patient became hypotensive and hypothermic. Mephyton was given and the bleeding diminished, but the hypotension persisted. The systolic pressure remained at 80 mm Hg with Aramine being administered. Aspiration of the pericardial sac was attempted Feb.

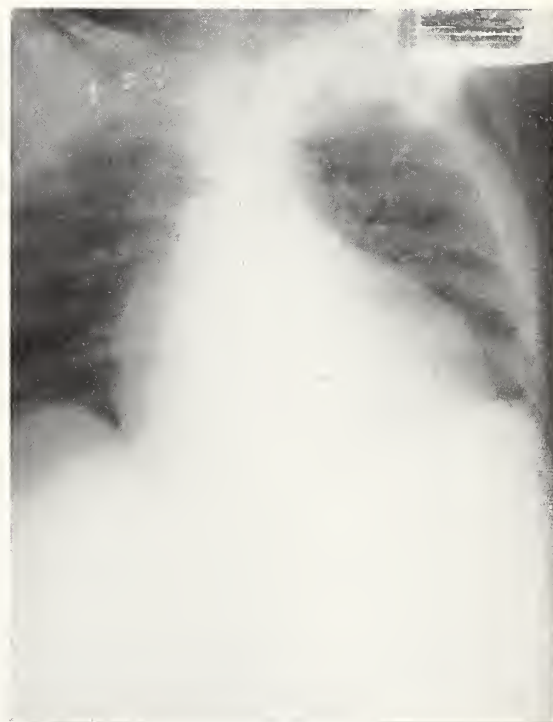


FIGURE 3
ROENTGENOGRAM of the chest, February, 1959. The heart is greatly enlarged and the lung fields are clear.

19, but only a small amount of bloody fluid was obtained. The blood urea nitrogen rose to 171 mg per 100 ml of blood on Feb. 20. The hypotension continued and the patient expired Feb. 24, 1959.

Autopsy

The body was that of a well-developed, well-nourished 70-year-old Negro male with gen-



FIGURE 4
SECTION OF THE MYOCARDIUM demonstrating the diffuse infiltration of amyloid. The myocardial fibers appear somewhat isolated and show mild degenerative changes. (H and E stain.)

eralized edema. The abdomen was distended and there was a small umbilical hernia. Stasis dermatitis of the lower extremities was extensive and numerous ulcers were present in the tibial areas. The peritoneal cavity contained an estimated 4 to 5 liters of dark yellow fluid. The left pleural space was almost obliterated by adhesions. The right pleural space contained an estimated 200 ml of dark straw-colored fluid and the pericardial sac an estimated 100 ml of similar fluid. Weight of the heart was 870 gms. Thickness of the left ventricular wall was 2.2 cm and that of the right ventricular wall was 1.0 cm. The valve circumferences were as follows: aortic, 8.0 cm; pulmonic, 9.0 cm; tricuspid, 14.0 cm; and mitral 12.0 cm. The coronary arteries were not thickened and no evidence of sclerotic change was found. Several small grey-white areas were distributed throughout the myocardium.

Weight of the right lung was 1350 gms and that of the left, 900 gms. Both lungs contained much frothy, foamy fluid. Weight of the spleen was 340 gms. A small amount of altered blood was found in the stomach but the remainder of the intestinal tract was not remarkable. Weight of the liver was 1500 gms and the surface was slightly granular. Weight of the left kidney was 200 gms and that of the right was 175 gms. There was a mass at the upper pole of the right kidney which measured 4 x 3.5 x 3 cm. On sectioning it was yellow, cystic, and hemorrhagic.

Microscopically, the myocardial fibers were

separated by a homogeneous, pale eosinophilic material. Many of the myocardial fibers were degenerated with loss of cross striations and loss of nuclei. With hemotoxylin and eosin stain the myocardial fibers stained from light pink to deep red (Figure 4). Sections stained with Congo red were pale pink. A diagnosis of amyloidosis of the heart of the atypical type was made. The lungs were congested and the alveoli contained much homogeneous eosinophilic material; diagnosis of pulmonary edema was made. The spleen and liver were congested and the kidneys demonstrated a moderate chronic pyelonephritis. The renal tumor was composed of large polyhedral cells, with pale cytoplasm and small nuclei. Papillary projections and hemorrhagic areas were noted. The tumor was well circumscribed, and was diagnosed as a renal adenoma.

Discussion

Amyloidosis is usually classified as (1) secondary, (2) primary, (3) amyloid tumor, and (4) amyloidosis associated with multiple myeloma.⁵ Secondary amyloidosis involves the liver, kidney, spleen and adrenals, and is usually associated with a chronic suppurative disease—tuberculosis and osteomyelitis being common examples. Primary amyloidosis involves mesenchymal tissue including the heart, tongue, intestinal tract, skin and lungs. In secondary amyloidosis the amyloid stains a brick red with a Congo red stain, but in primary amyloidosis the reaction is variable.

King² proposed to classify amyloidosis as "typical" or "atypical" based on the staining reaction. This proposal has merit in that occasionally there is overlapping of the organs involved, such as the liver being the site of primary amyloidosis.⁶ Amyloidosis associated with multiple myeloma is similar to primary amyloidosis in both the organs involved and the staining reactions, but it has the association of myeloma cells. The heart is the organ most frequently involved in both of these types.⁷ Amyloid tumor consists of nodules of amyloid deposited in the subcutaneous tissue or beneath the mucous membranes.

Although amyloid was first described more than 100 years ago, the exact nature of this substance has not yet been established. A genetic relationship has been proposed, as has an antigen-antibody concept.⁸ Since amyloid has a variable staining reaction it has been suggested that it is probably a series of closely related protein compounds.⁹ In addition to the protein, most amyloids contain two carbohydrate components, one an acid mucopolysaccharide and the other probably a glycoprotein.¹⁰

In the heart the amyloid is deposited on the reticulum fibers surrounding the individual myocardial fibers, so that on cross-section the muscle fibers appear to be encased by a ring of amyloid.¹¹ It may also affect the heart by being deposited in the cardiac blood vessels, on the valves or in the pericardium or endocardium.¹² In the case under discussion the amyloid was diffusely infiltrated, separating the myocardial fibers. Diffuse infiltration of amyloid interferes with the normal range of contraction and relaxation of the cardiac chambers,¹² and as in constrictive pericarditis and endocardial fibroelastosis, there is predominantly right-sided heart failure. Our patient presented this type clinical picture, with occasional episodes of pulmonary edema. In all such cases of clinically obscure heart disease the possibility of primary amyloidosis must be considered.⁹

Non-Specific EKG Findings

Electrocardiographic findings in this case were non-specific, but this situation is the usual observation in amyloidosis of the heart.^{3, 9} Auricular fibrillation was noted on several occasions and this finding has been stressed as a frequent condition in amyloidosis involving the heart,

particularly if the auricular infiltration is severe. Conduction disturbances, low voltage in the limb leads, and in some instances the changes suggestive of an old antero-septal infarct are other electrocardiographic findings that have been reported.¹³ One aid in the diagnosis of amyloidosis is the Congo red test, but the results are frequently equivocal,^{1, 14} and the test is even less reliable in primary amyloidosis than in secondary amyloidosis.⁷ A biopsy of the skin or tongue may be of aid but in this patient there was no apparent involvement of these structures.

We wish to classify this case as one of "Primary Cardiac Amyloidosis" for the following reasons:

1. Amyloid deposition was limited to the heart.
2. The staining reaction to Congo red was atypical.
3. There was an absence of any specific etiologic factor.
4. The patient was in an older age group than in patients with primary or secondary amyloidosis.

Although the patient had a positive serologic test for syphilis no other evidence of syphilis was noted on examination of the body. We believe that this disease was latent and had no role in the development of the cardiac lesion. The renal lesions are also considered as incidental findings. The patient's prolonged clinical course is similar to that reported in patients with primary amyloidosis as opposed to the fact that most patients with secondary amyloidosis do not survive more than one year after the onset of symptoms.¹⁵ There is no known treatment for primary amyloidosis and no cures have been reported.^{1, 6}

Summary

A case of an elderly Negro male with prolonged congestive heart failure is presented. At autopsy the heart was found to be the site of amyloid deposition. Reasons are given for classifying this as "Primary Cardiac Amyloidosis." This diagnosis should be included in the differential diagnosis of all cases of clinically obscure heart disease.

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Garden Fever

Dear Stephen: I am so sorry you are feeling less well. How is the phlebitis? No one ought to suffer from anything with such a pretty name. Did you ever stop to think that the names of diseases and the names of flowers are very similar? For instance, I might say, "Do come and see my garden. It is at its best now, and the double pneumonias are really wonderful. I suppose the mild winter had something to do with that. I'm very proud of my trailing phlebitis, too, and the laryngitises and deep-purple quinsies that I put in last year are a joy to behold. The bed of asthmas and malarias that you used to admire is finer than ever this summer, and the dear little dropsies are all in bloom down by the lake and make such a pretty showing with the blue of the anthrax border behind them."

—Letter from a novel by S. Ertz: *Madame Claire*, New York: D. Appleton & Company, 1924. Reprinted in the *JAMA*, Jan. 28, 1961.

Negative Association of Coronary Atherosclerosis With Liver Cirrhosis and Chronic Alcoholism —A Statistical Fallacy*

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THE RELATIONSHIP of portal cirrhosis and chronic alcoholism to coronary atherosclerosis remains a controversial issue. Prior to 1900 chronic alcoholism was believed to be one of the causes of arteriosclerosis. According to Leary,¹ "The legend that alcohol was responsible for the production of arteriosclerosis has come down to us from an early period. The confusion of syphilitic arterial disease with arteriosclerosis, and the frequent relation of alcoholism and syphilis may have been a factor leading to this belief." Cabot² was one of the first to suggest that alcoholism does not cause arteriosclerosis. Of 283 chronic alcoholics under 50 years of age, Cabot found only six percent with clinical evidence of arteriosclerosis. Furthermore, Cabot reported that only 17% of 95 autopsied patients with arteriosclerosis used alcohol in excess.

Several more recent studies^{1,3,4,5,6} suggest that chronic alcoholism and/or cirrhosis of the liver afford some protection against the development of atherosclerosis. Leary¹ observed at post-mortem examinations that chronic alcoholics had less severe aortic arteriosclerotic changes than nonalcoholics. He commented that, "When in a man of 60, an aorta consistent with age 40 is found at postmortem examination, and when

investigation then discloses for the first time a history of alcoholism, it gives one cause to think." Perhaps this finding would give many people cause to drink.

Chase and his associates³ analyzed the causes of death among 66 patients with Laennec's cirrhosis and did not mention finding any coronary artery disease or myocardial infarction. Pollard et al.⁴ studied 201 patients with alcoholic cirrhosis and reported that six patients had coronary artery disease (three patients had myocardial infarction and three had angina pectoris). Hall, Olsen and Davis⁵ reviewed 782 cases of portal cirrhosis among 16,600 necropsies performed at the Los Angeles County Hospital from 1933-1946. They found that at age 55 about 75% of the male controls showed moderate to severe coronary sclerosis. The corresponding figure for cirrhotic patients was only 30 to 35%.

Howell and Manion⁶ studied 639 necropsies of cirrhotics and a five percent sample of 17,731 noncirrhotic necropsies at the Armed Forces Institute of Pathology and reported that only 4.9% of the cirrhotics in contrast to 20.2% of the noncirrhotics had myocardial infarction. Creed and his associates⁷ found that patients with Laennec's cirrhosis had significantly less severe aortic arteriosclerosis than the controls among 1,223 necropsied patients.

Indicate Heart Disease Common

Other studies indicate that coronary heart disease is rather commonplace among patients with chronic alcoholism and cirrhosis of the liver,

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* This paper is based on a larger study of the epidemiology of coronary heart disease in partial fulfillment of the requirements for the degree of Doctor of Public Health from Yale University School of Medicine.

Lunseth et al.⁸ stated that 52 (48%) of 108 patients dying with portal cirrhosis which they studied had serious heart disease. Of these, 26 had arteriosclerotic heart disease (15 with moderate myocardial fibrosis and 11 with severe myocardial infarction).

In a very important study, Wilens⁹ compared the pathologic findings of 519 chronic alcoholics with those of 600 consecutive total abstainers and moderate consumers of alcohol. He found that 9.3% of the alcoholics in contrast to 21% of the nonalcoholics had severe coronary atherosclerosis. Also, 6.4% of the alcoholics versus 15.2% of the nonalcoholics had myocardial infarcts. Wilens astutely attributed the low prevalence of atherosclerosis among chronic alcoholics to: (1) the younger age at which persons with chronic alcoholism die and (2) to the low prevalence in alcoholics of atherogenic conditions such as hypertension, diabetes mellitus and obesity. Taking these factors into consideration, Wilens concluded that alcohol has no appreciable effect on the development of atherosclerosis.

The purpose of this study is to examine the controversial relationship of chronic alcoholism and liver cirrhosis to coronary atherosclerosis. This study differs from previous necropsy studies in that techniques of chronic disease epidemiology, including biostatistics, are used to examine these relationships. Is the reported negative association of coronary atherosclerosis with liver cirrhosis and chronic alcoholism an "apparent" or a "real" association?

Materials and Methods

The necropsy records used for this study were obtained from the Grace-New Haven Community Hospital, New Haven, Conn., which is associated with the Department of Pathology of the Yale University Medical School. From 1935 through 1955 (a 21-year period) 2,909 autopsies were performed on white males 40 or more years of age. However, only in 2,731 (94%) of the records were the coronary arteries described in sufficient detail to be included in this study. The study was limited to white males of 40 or more years because coronary atherosclerosis, cirrhosis of the liver and chronic alcoholism are prevalent in this group of patients.

Disease Groups—The necropsy records were divided into the following disease groups: (1) those dying with cirrhosis of the liver; (2) those dying with a history of chronic alcoholism;

(3) those dying from accidental causes; (4) those dying with all causes of death except cirrhosis (noncirrhotics); and (5) those dying with all causes of death except chronic alcoholism (nonalcoholics).

The liver cirrhosis group included those patients having a diagnosis of Laennec's cirrhosis or portal cirrhosis. Patients having a diagnosis of cardiac cirrhosis, postnecrotic cirrhosis, biliary cirrhosis, hemochromatosis, syphilitic cirrhosis and hepatolenticular degeneration were excluded from the cirrhosis group. If a patient with liver cirrhosis, as defined, was found to have a concomitant history of chronic alcoholism, his record was placed in the cirrhosis group. Forty-nine (54%) of the cirrhotic patients had a history of chronic alcoholism.

The chronic alcoholic group consisted of any patient whose necropsy record or clinical chart listed chronic alcoholism as a diagnosis. These patients may or may not have had some liver pathology. However, if a patient with a history of chronic alcoholism had liver cirrhosis, as defined, his record was placed in the cirrhosis group.

The accident group consisted of passengers who died from injuries sustained in automobile accidents. Drivers were excluded from the study. If a victim had been drinking at the time of death, his record was not used in either the accident group or the chronic alcoholic group. Accident victims were selected as a control group because these patients were not admitted to the autopsy population for a specific illness. Thus, the events which caused death have little "known" selectivity in so far as the victims' coronary arteries are concerned. It seemed reasonable that accident victims are the group in the autopsy population who most likely represent the general population.

Coronary Arteries Compared

The relationship between liver cirrhosis and coronary atherosclerosis was studied in the conventional manner used by other investigators. Namely, to compare the coronary arteries of cirrhotics with the coronary arteries of all noncirrhotics in the autopsy population. Thus, the noncirrhotic group consisted of patients dying with and from every disease or condition except cirrhosis of the liver. This group included accident victims and chronic alcoholics who did not have cirrhosis.

Likewise, the relationship between chronic alcoholism and coronary atherosclerosis was examined in the traditional manner. The coronary arteries of chronic alcoholics, as defined, were compared with those of all nonalcoholics in the autopsy population. The nonalcoholic group included patients dying with and from every cause of death except chronic alcoholism. The non-alcoholic group included accident victims and patients with liver cirrhosis, as defined.

Certain diseases are associated with the development of coronary artery disease. They include diabetes mellitus, familial xanthomatosis, essential hyperlipemia, myxedema, syphilitic coronary narrowing, thromboangiitis obliterans, polycythemia, infectious diseases producing coronary arteritis, aneurysms and neoplasms. Cirrhotic, alcoholic and accident patients having concomitant diagnoses of diabetes mellitus were eliminated from their respective disease groups. Inspection of the records showed that none of the other diseases listed above were a major source of bias in comparing cirrhotics, alcoholics and accident victims with each other.

Classification of Coronary Pathology—The grading of coronary artery atherosclerotic blockage in this study was based primarily on the macroscopic description of the arteries. Coronary artery blockage was classified as follows:

Grade Coronary Blockage Due to Atherosclerosis

- O — Cases without macroscopic evidence of atherosclerosis or thickening and scarring of the vessel wall.
- I — Cases showing atherosclerotic changes as indicated by plaques, thickening of the vessel wall and calcification in which narrowing of the vessel lumen ranged from one to 49%.
- II — Cases showing atherosclerotic changes which produced narrowing of the vessel lumen from 50 to 89%.
- III — Cases with atherosclerotic changes producing narrowing of the vessel lumen from 90 to 99%.
- IV — Cases with atherosclerotic lesions which completely obliterated the vessel lumen —100% blockage.

Three serious limitations of the retrospective (case) method of study—incomplete records, lack of uniformity and more detailed descriptions of interesting cases—were not encountered

in this study. More than one pathologist reviewed each autopsy at the time it was performed. The technic of examining the coronary arteries and the method of recording the findings did not change materially over the years. Three observers were given a random sample of necropsy heart descriptions and each one was asked to independently classify the coronary arteries into the various grades of blockage. There was a high percentage of agreement among the observers as to which grades the cases should be assigned.

Matching Records

Race and sex were matched by limiting this study to white male patients. Age was adjusted for by using the "balancing" technic described by Cochran.¹⁰ The records were balanced so that the mean age for the cirrhosis, chronic alcoholic and accident groups was equal. In no instance was a record used in this balancing process, if the difference in patients' ages was greater than five years. Since there is indirect evidence that the prevalence of coronary artery disease is on the increase, the year of these patients' death was matched by five-year periods (for example, 1935-1939, 1940-1944, 1945-1949, etc.). Thus, in Table I the records are matched so that for each cirrhotic there is a corresponding chronic alcoholic and accident victim of the same race and sex, who died at approximately the same age, and during the same five-year period.

Hypertension was not a major source of bias in Table I, since 32% of the cirrhotics, 29% of the chronic alcoholics and 25% of the accident victims had hypertension. The criterion for hypertension in this study is based on the data published by Lasser and Master.¹¹

Obesity is another factor which has been implicated in coronary atherosclerosis. Therefore, the Metropolitan Life Insurance Company data on the height and weight of white males over 25 years of age were used to calculate the percentage of patients who were 15% or more underweight and those who were 15% or more overweight. The percentages of underweight patients were: liver cirrhosis—11% ; chronic alcoholics—18% ; and accident victims—13%. The percentages of overweight patients were: liver cirrhosis—32% ; chronic alcoholics—24% ; and accident victims—27%. Patients in the normal range of body weights in these three disease

**COMPARISON OF CORONARY ARTERY ATHEROSCLEROTIC BLOCKAGE
AMONG MATCHED LIVER CIRRHOSIS, CHRONIC ALCOHOLIC AND
ACCIDENT PATIENTS.**

Disease Group	Grade Coronary Atherosclerotic Blockage*					Total
	0	I	II	III	IV	
Cirrhosis	20	49	16	5	1	91
Alcoholic	25	51	10	4	1	91
Accident	22	48	13	6	2	91
Total	67	148	39	15	4	273

* Grade Blockage
0 = None
I = 1-49%
II = 50-89%
III = 90-99%
IV = 100%

Results: $X^2 = 2.948$
d.f. = 8
 $p = < .95$ but $> .90$
(not significant)

TABLE I

**COMPARISON OF CORONARY ARTERY ATHEROSCLEROTIC BLOCKAGE
AMONG CIRRHOTIC PATIENTS AND ALL OTHER (NONCIRRHOTIC)
PATIENTS IN AN AUTOPSY POPULATION.**

Disease Group	Grade Coronary Atherosclerotic Blockage*										Total	
	0		I		II		III		IV			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Cirrhotics	20	(22)	49	(54)	16	(18)	5	(5)	1	(1)	91	(100)
Noncirrhotics	665	(25)	1031	(39)	443	(17)	387	(15)	114	(4)	2640	(100)
Total	685	(25)	1080	(40)	459	(17)	392	(14)	115	(4)	2731	(100)

* Grade Blockage: See Table I
Results: $X^2 = 12.560$; d.f. = 4; $p = < .02$ but $> .01$ (significant)

TABLE II

groups were compared and no significant differences in the prevalence or severity of coronary atherosclerosis were found. Therefore, differences in body weights would not seem to be a source of bias in this study. It should be pointed out, however, that body weight at time of death is a nebulous measurement which may not reflect a person's weight status throughout most of life.

Results

Table I shows a comparison of coronary atherosclerotic blockage among 91 cirrhotics, 91 alcoholics and 91 accident victims. These data indicate that the prevalence and severity of coronary atherosclerotic blockage among these three disease groups are very similar. None of these

differences were statistically significant ($X^2 = 2.948$; d.f. = 8; $p = < .95$ but $> .90$). Therefore, patients with liver cirrhosis and chronic alcoholism have about the same prevalence and severity of coronary atherosclerotic blockage as do accident victims.

On the other hand, a comparison of coronary atherosclerotic blockage among cirrhotics versus all other patients (noncirrhotics) in the autopsy population provides strikingly different results. Table II shows that a smaller percentage of cirrhotics have grades III and IV atherosclerotic blockage than was found among noncirrhotics. These differences were statistically significant for white males 40-79 years of age ($X^2 = 12.560$; d.f. = 4; $p = < .02$ but $> .01$). This analysis would seem to indicate that cirrhotics

**COMPARISON OF CORONARY ARTERY ATHEROSCLEROTIC BLOCKAGE
AMONG CHRONIC ALCOHOLIC PATIENTS AND ALL OTHER (NONAL-
COHOLIC) PATIENTS IN AN AUTOPSY POPULATION.**

Disease Group	Grade Coronary Atherosclerotic Blockage*											
	0		I		II		III		IV		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Alcoholics	25	(28)	51	(56)	10	(11)	4	(4)	1	(1)	91	(100)
Nonalcoholics	660	(25)	1029	(39)	449	(17)	388	(15)	114	(4)	2640	(100)
Total	685	(25)	1080	(40)	459	(17)	392	(14)	115	(4)	2731	(100)

* Grade Blockage: See Table I

Results: $X^2 = 17.257$; d.f. = 4; $p = < .01$ (significant)

TABLE III

have significantly less severe coronary atherosclerotic blockage than all other patients (non-cirrhotics) in the autopsy population. This conflicting finding will be discussed later.

Similarly chronic alcoholics 40-79 years of age, were found to have significantly less severe coronary atherosclerotic blockage than all other patients (nonalcoholics) in the autopsy population. Table III shows that four percent of the alcoholics in contrast to 15% of the nonalcoholics had Grade III blockage. Also, only one percent of the alcoholics versus four percent of the non-alcoholics had Grade IV blockage. These differences were statistically significant ($X^2 = 17.257$; d.f. = 4; $p = < .01$).

Discussion

Usually an autopsy population is a biased population, because everyone who dies does not come to autopsy. Furthermore, not everyone who dies is admitted to a hospital population. Few hospitals in the United States have 100% autopsy rates. Mainland¹² has presented an interesting discussion of the various antemortem and post-mortem factors which may influence the selection or rejection of a patient to an autopsy population. Other biostatisticians^{13, 14} have warned that there are many pitfalls and sources of bias in using autopsy data for studies.

Berkson¹⁵ of the Mayo Clinic pointed out a very serious fallacy which may occur in autopsy studies under the two following sets of circumstances: (1) if two diseases in the same person

increase the probability of his admission to the autopsy population or (2) if persons with the diseases are not represented in the autopsy population in the same proportion that they are found in the general population. Kraus¹⁶ felt that Berkson's fallacy is less likely to occur when a characteristic is compared with a disease than when two or more diseases are compared with each other. Kraus reasoned that a characteristic, such as eye color, probably would not greatly influence a person's admission to a hospital or to an autopsy population. Likewise, the coronary arteries of automobile "passengers" killed accidentally would not be expected to influence their admission to an autopsy population. Accident victims' coronary arteries probably are more representative of the coronaries of the general population than those of any other group of patients in an autopsy population.

Conflicting results were found in this study. Table I shows that cirrhotics and chronic alcoholics have about the same prevalence and severity of coronary atherosclerosis as do accident victims. On the other hand, the data in Tables II and III show that cirrhotics and chronic alcoholics have significantly less severe coronary atherosclerosis than do noncirrhotics and non-alcoholics, respectively. Obviously, these conflicting results cannot both be correct. All of these data were obtained from the same autopsy population, hence different sources of data cannot account for these conflicting results. Errors in the statistical analyses of these data cannot be blamed for this paradox. A fallacy in the

**PREVALENCE OF MALE DIABETICS, 45-74 YEARS OF AGE, IN THE
GENERAL POPULATION OF OXFORD, MASSACHUSETTS AND IN THE
AUTOPSY POPULATION OF NEW HAVEN, CONNECTICUT.**

Oxford, Mass.				New Haven, Conn.		
Age Group	Gen. Pop.	Estimated ¹ No. Diabetics	Rate per 100	Autopsy Pop.	Observed No. Diabetics	Expected ² No. Diabetics
45-54	275	11.0	4.0	563	29	22.5
55-64	216	4.4	2.0	697	41	13.9
65-74	158	7.7	4.9	661	46	32.4
Total	649	23.1	—	1921	116	68.8

1. Based on known cases plus newly discovered cases of diabetes and adjusted for the total general population of Oxford, Mass. (Ref. No. 17).
2. The number of diabetics which one would expect to find in the autopsy population, if the age-adjusted prevalence rates for males in the general population of Oxford, Mass. held true. Since more diabetics were observed than were expected in the autopsy population, the autopsy population is heavily weighted with diabetics.

TABLE IV

basic design of the experiment could, and did, produce these contradictory findings.

Examples of Berkson's Fallacy

Two examples of Berkson's fallacy were found in this autopsy study. The data used in Tables II and III are biased and produce fallacious conclusions. Patients in this autopsy population who did not have cirrhosis (noncirrhotics) and who did not have chronic alcoholism (non-alcoholics) were heavily weighted with atherogenic conditions such as diabetes mellitus, arteriosclerotic heart disease and hypertension. In other words, the noncirrhotics and nonalcoholics used for the analyses in Tables II and III had a higher proportion of their number with these atherogenic conditions than one would find in the general population.

Table IV compares the prevalence of diabetes mellitus found in the general population of Oxford, Mass.¹⁷ with that found in the autopsy population in New Haven, Conn. (which is the basis for this study). If the prevalence rates for Oxford, Mass. held true for the autopsy population, then one would "expect" to find 69 diabetics. However, 116 diabetics were "observed" or found in this autopsy population. Thus, the autopsy population is heavily weighted for diabetes mellitus, an atherogenic disease. Similarly, the arteriosclerotic heart disease prevalence rates for males, 45-62 years of age, reported for the general population of Framingham, Mass.¹⁸ were compared with those for the

New Haven, Conn. autopsy population. If the Framingham, Mass. rates held true for the autopsy population then 52 cases of arteriosclerotic heart disease would be expected in the autopsy population. However, 154 cases of arteriosclerotic heart disease were observed in the autopsy population. Thus, the autopsy population was weighted with about three times as many cases of arteriosclerotic heart disease as one would find in the general population.

Weighting of the noncirrhotic and the non-alcoholic groups with excessive amounts of severe coronary atherosclerosis produced the erroneous negative association between this condition and liver cirrhosis and chronic alcoholism found in Tables II and III. Thus, two concrete examples of Berkson's fallacy were found in this study.

Many of the previous studies^{1,3,4} which indicated that patients with cirrhosis and chronic alcoholism have little coronary atherosclerosis did not have control groups for comparative purposes. These studies merely described the autopsy findings among cirrhotics and chronic alcoholics. The studies of Hall, Olsen and Davis,⁵ Howell and Manion⁶ and Creed, Baird and Fisher⁷ indicated that patients with liver cirrhosis had less coronary and/or aortic atherosclerosis than control groups comprised of patients with all other diseases (noncirrhotics). In our opinion, their conclusions are erroneous and probably resulted from Berkson's fallacy.

Our findings are in agreement with those of

Wilens⁹ and would tend to invalidate those of other investigators. There is no association—either positive or negative—between liver cirrhosis and coronary atherosclerosis or between chronic alcoholism and coronary atherosclerosis.

Summary

1. Previous studies suggest that liver cirrhosis and chronic alcoholism afford some protection against the development of coronary atherosclerosis. The present study indicates that this association is "apparent," owing to a statistical fallacy, rather than "real."
2. There were no statistically significant differences in the prevalence and severity of coronary atherosclerotic blockage when cirrhotics and chronic alcoholics were compared with automobile accident victims. The coronary arteries of accident victims should be reasonably representative of the coronary arteries of the general population.
3. On the other hand, cirrhotics had significantly less severe coronary atherosclerotic blockage than all other (noncirrhotic) patients in the autopsy population. Likewise, chronic alcoholics had significantly less severe coronary atherosclerotic blockage than all other (nonalcoholic) patients in the autopsy population.
4. The noncirrhotics and nonalcoholics which were compared with the cirrhotics and alcoholics, respectively, were heavily weighted with atherogenic conditions such as diabetes mellitus and arteriosclerotic heart disease. In other words, there were higher proportions of patients with diabetes and arteriosclerotic heart disease in the autopsy population than one would find in the general population. Therefore, an "apparent" but erroneous negative association of coronary atherosclerosis with cirrhosis and chronic alcoholism was produced.
5. It was concluded that there is no association—either positive or negative—between liver cirrhosis and coronary atherosclerosis or between chronic alcoholism and coronary atherosclerosis.

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LABORATORY MEDICINE

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Sickle Cell Preparation

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Indianapolis

IN RECENT YEARS there has been much emphasis on the biochemistry of hereditary and familial diseases such as sickle cell anemia. This hereditary and familial disease is more common in Negroes and is a form of chronic, hemolytic anemia. Morphologically it is distinctive because of the presence of sickle-shaped red corpuscles. The condition was first described by Herrick in 1910 and is sometimes referred to as drepanocytic anemia or meniscocytosis.

Recent research has shown us that many of the morphological abnormalities of red cells and resulting clinical syndromes are associated with the presence of abnormal hemoglobins. If an erythrocyte contains hemoglobin S (as is true in sickle cell anemia), it will undergo bizarre shape changes if the oxygen tension or the pH is reduced. The shape change is probably due to the insolubility of reduced hemoglobin S which, in pure crystalline form, has been shown to assume the sickle shape.

Occasionally sickling can be seen in routine smears. Sickling in sickle-cell anemia can be induced by venous stasis, by placing a drop of blood on a slide and sealing it with a coverslip, or by adding reducing agents such as sodium metabisulfite or sodium dithionite. Sickle-cell

disease occurs in the heterozygous form as the sickle-cell trait and in the homozygous form as sickle cell anemia. The sickle-cell trait is relatively asymptomatic while sickle cell anemia is characterized by a severe hemolytic anemia. Electrophoretic hemoglobin analysis makes it possible to differentiate between these two entities. It is known, however, that if a red cell containing hemoglobin S is exposed to a powerful reducing agent, sickling will occur in both the sickle-cell trait and sickle cell anemia. Anoxia will produce sickling in the sickle-cell anemia but no reaction in the sickle cell trait. This is the basis of the test proposed by Sherman. It is the practice in many laboratories to use sodium metabisulfite only as a screening test for the presence of hemoglobin S and to distinguish anemia from trait with the Sherman test.

Methods

Sodium Metabisulfite Method: One-two drops of 2% aqueous sodium metabisulfite are added to one drop of capillary or venous blood on a glass slide. After mixing, a coverglass is dropped on to the preparation and the excess blood is expressed by gently pressing the coverglass with a gauze square or filter paper. This produces a wet preparation which is thin enough to permit the examination of individual cells. Examine immediately and at intervals of 15 and 30 min-

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utes under high power for sickling, count the number of sickle cells in a total of 1000 red cells and divide by 10 to obtain the percent of sickled cells present. Set up a control in the same manner using 0.85% NaCl in place of sodium metabisulfite.

When a fresh solution of sodium metabisulfite is used, it gives rapid and reproducible results, e.g., 10-75% sickling within 15 minutes. If there is no sickling within 30 minutes, the sickle-cell test is reported as negative. The test is considered positive if 10% or more of the red cells show a sickled form. A sickle cell should have both ends pointed; otherwise it is considered a poikilocyte.

Sherman Test

Place .2 ml of 10% formalin solution in a small medicine glass and cover with a layer of mineral oil. Fill the dead space of a 5 ml syringe with mineral oil and expel the excess. Place a sterile needle on the syringe and withdraw 2 ml of blood by venepuncture. Leave the needle on the syringe and immediately deliver 1 ml of blood below the layer of oil in the medicine glass. Mix by stirring with a glass rod. Let the

mixture stand 10 minutes; then remove a small amount of the blood mixture with a capillary pipet. Place a drop of the mixture on a slide, cover with a coverglass, and examine for sickle cells under high power. Count 1000 erythrocytes and give the percentage of sickled cells present.

Sickle-cell trait shows one percent or less sickled erythrocytes. Sickle-cell anemia shows more than one percent sickled erythrocytes, usually 30 to 60 percent.

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The Inquiring Mind

An apparent paradox is found throughout medical life: from student to venerable practitioner an inquiring mind is postulated or professed, and yet all medical ages have a most persistent desire to cling to authority. The dogmatism of Galen dominated medical thought for a thousand years, until the inquiries of minds such as those of Vesalius and William Harvey opened the way to the extension of knowledge. The wish for authority did not die, however, and there were bitter struggles between rival schools contending for dominance—the humoralists versus the solidists, the Brunonians versus the Broussaisians, the homeopaths versus the regulars.

Today we read of these dissensions with complacent tolerance, secure in our thoughts that medicine is now firmly based on scientific truth and that the enormous extensions of knowledge provided by the biological sciences within the last century have revolutionized medical philosophy. It could be argued, however, that the desire for authority is still with us, and that one of the fundamental problems of medicine today is the multiplicity of authorities; there is a babel of voices claiming our attention.—H. N. Robson: The Inquiring Mind, editorial. *Australasian Annals of Medicine*, May 9, 1960; reprinted in *J.A.M.A.*, Jan. 21, 1961.



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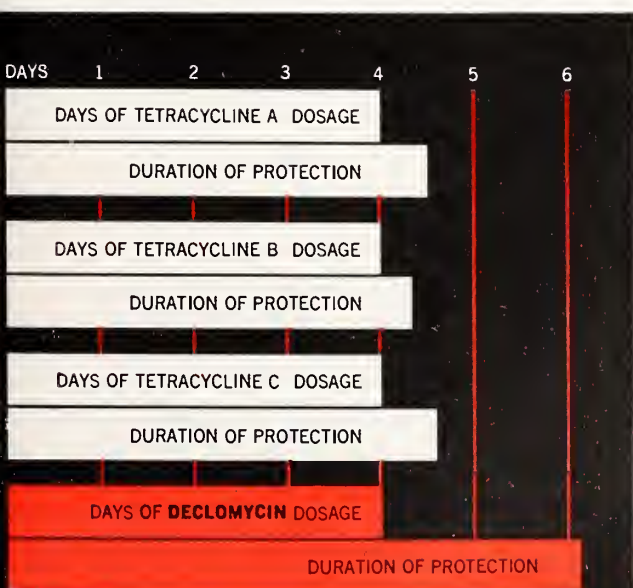
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Be Wary of Cut-Rate Services

ALMOST ALL medical laboratory tests, even when conscientiously performed by highly trained personnel, fall short of 100% reliability, to a small degree. Laboratory tests when carelessly or unskillfully performed fall short of reliability so far as to be useless.

Unreliable laboratory data are worse than no data at all. Physicians would prefer to treat patients with no laboratory aid rather than try to depend on carelessly done work.

The best clinical laboratories are supervised by doctors of medicine. When laboratory tests are offered by an organization devoid of medical supervision, when such work is done on a mail-order basis and when quantity discounts are offered, it is time to be wary.

A laboratory by the name of Indiana Medical Laboratory Service with a post-office box number as its only address has been circularizing the profession and soliciting business on a cut-rate price schedule and mail-order basis. The most recent circular suggests that a certified pathologist was examining all pathology specimens and therefore suggests that the laboratory is under his direction. It also states that a fa-

mous specialist would be consulted in all questionable cases. Evidence indicates that this "pathologist" is not a certified pathologist, and that the specialist is in no way affiliated with the laboratory.

The cut-rate fees are stated to be justified by mention of automation and high-volume work. However, the most recent circular suggests this as a method to increase the referring physician's own income, an arrangement which admits of rebate practices for anyone commercially minded enough to take advantage of it, to the disadvantage of the patient.

The entire scheme bears the characteristics of a questionable and unethical venture.

Medical care should be done as economically as possible, consistent with reliable tests and good results. Cut-rate work is not consistent with reliability. Physicians at all times should be informed as to the integrity and ability of those from whom they seek professional aid. A laboratory service which is identified only by a post-office box number and which has already been shown to use misleading advertising does not qualify.

One Thing and Another

IN WISCONSIN the medical profession has for some time been involved in controversy (at times much bickering) concerning Blue Cross, Blue Shield, Wisconsin Physicians Service and Health Insurance Corporation.

We in Indiana have encountered some difficulties, centered for the most part around problems of anesthesiologists, radiologists and pathologists. In Wisconsin, however, the situation has been much more serious, so that the profession there is very alert and sensitive to any straws in the wind stirred up by those seeking power over the medical profession.

Lest we become apathetic, let us hear a voice from Wisconsin, published in the *Wisconsin Medical Journal*, December, 1960, and quoted here in part:

"If there was any doubt of the intentions of the Blue Cross plans as they face their most serious financial crisis, Dr. Basil C. MacLean, former president of Blue Cross Association, recently spelled out the program in unmistakable terms. Blue Cross, says Doctor MacLean, must go 'beyond merely competing with, or imitating the insurance companies . . . the Blue Cross symbol must mean complete coverage, without any qualifications, for all services that are provided in hospitals.'

"Quoted in an article in *Medical World News* of November 4, 1960, Doctor MacLean is a former hospital administrator, a former commissioner of hospitals in New York City and former head of the American Hospital Association. He obviously is smarting under the failure of Blue Cross to keep pace with commercial competition in the voluntary prepayment field, and he is cleverly mounting the drive for hospital control of medical services on his alibi for that failure.

"The truth of the matter is quite simple: commercial competition in the field of prepaid hospital care has cut into Blue Cross enrollment merely because it is able to offer comparable or superior benefits at comparable or lower costs to more people. For years Blue Cross nationally had a toe-hold on the health insurance market. It selected its risk, excluding the elderly, avoiding the less profitable nongroup policies, except at exorbitant cost. At the same time, Blue Cross increased its rates so much that commercial insurance companies could compete at a profit and offer the public coverage that Blue Cross omitted.

"So far, Blue Cross' problem is strictly its own. It is selling hospital insurance and nothing else. As a convenience—and only as a convenience—Blue Cross is frequently sold with Blue Shield coverage. Here in Wisconsin Blue Cross was dissociated from the Blue Shield plan of the State Medical Society, Wisconsin Physicians Service (WPS). The latter was able to

continue successfully on its own merits. But Blue Cross found it necessary to find a competing medical-surgical plan in order to sell its own plan. Experience in our own state proves Blue Cross needs Blue Shield, but Blue Shield can get along nicely without Blue Cross."

* * * * *

"Doctor MacLean's solution is to incorporate Blue Shield into Blue Cross; and, presumably, by extending the stodgy self-righteousness and the proven inability of Blue Cross to compete, the hospital association will be able to take business away from private firms.

"Doctor MacLean refers to Blue Shield as the 'monkey on the back of Blue Cross.' Blue Cross, he claims, could move faster without it. Perhaps he means faster down the road to total insolvency. For the facts belie his words.

"We have seen the Blue Shield monkey get off the back of Blue Cross in Wisconsin. And Blue Cross, instead of capitalizing on this freedom—instead of moving faster—immediately found itself another monkey to put on its back. It persuaded the doctors of Milwaukee county to permit their Surgical Care plan to be sold statewide in competition to the WPS plan, which, incidentally, is also their plan. This episode raises the question as to which monkey is riding on whose back.

"Doctor MacLean and Blue Cross are fond of exclaiming that the future of voluntary prepayment for health care is intimately involved with the future of Blue Cross. This is arrant nonsense. Private insurance companies are competing with both Blue Shield and Blue Cross, and this is, indeed, as it should be. If private companies can provide satisfactory health insurance and make a profit, it behooves the so-called not-for-profit plans to review their situation and either offer better coverage at lower prices or go out of business.

"This would be logical. But Doctor MacLean and the Blue Cross Association aren't particularly interested in logic at this point. They are interested in power. Behind the sententious effluvia emanating from Doctor MacLean's holier-than-thou interview article was the substance of Blue Cross' hope ultimately to control medical services in hospitals, and thereby all medical practice. The first step is to obtain control of certain medical services. Let hospitals charge for radiological, pathological and anaesthesiological services, says Doctor MacLean, so Blue Cross can cover them. The hospital is the only place for diagnosis, says he, so we ought to control that too. Next Blue Cross will decide what service will be delivered to whom and who will do the delivering. Finally, Doctor MacLean holds up the spectre of government interference in the health care field, blithely ignoring that he has just described the worst features of government interference as desiderata for Blue Cross' success.

"Blue Cross' bid for power is not new. We have been confronted with it in its naked form in our own state, and we are succeeding in our effort to stymie it

at least locally. Nationally, Blue Cross is in trouble, and its contention that it can save itself by involving a companion service in its own trouble is fatally unrealistic. But it sounds good, and if we accept the false premise that only Blue Cross can provide health care insurance, we are stepping into the trap that Doctor MacLean and the Blue Cross Association have prepared for us.

"The issue here, as in the fight against government intervention in the field of health care, is the inde-

pendence of the medical profession. Doctors use hospitals: hospitals don't use doctors. To protect this status, we must insist that the established relationships be respected and that control of medical practice remain with the doctors. We must be alert to the attack from Blue Cross no matter how it is disguised. We must resist the siren song of those who try to prey on our natural aversion to interference in our profession as a means of accomplishing the very interference we abhor."

—A.W.C.

From Maryland

Sensitivity to Penicillin

THE PROBLEM OF PENICILLIN'S status in therapy has been rendered acute by the great furor raised, in the recent past, over possible allergic reactions. It must be remembered that the introduction of this first "miracle drug" to the medical profession made possible control of infections theretofore beyond our power to control. But, as so frequently happens, adverse reports began to appear, which cited the development of sensitivity and caused the pendulum to swing from unanimous approval to condemnation in many quarters.

Many factors must be considered in the use of a therapeutic agent, one being the economic effect on the patient. Penicillin is much less costly than the "mycin" drugs. To bow to an almost hysterical fear of a possible reaction and, thus, to discard it offhand would be unjustified. In my opinion, the chief cause of penicillin reactions has been improper administration.

Some years ago, over a period of possibly 18 months, I used a great deal of one of the original depository types, the administration of which was necessarily parenteral. At first, this was most effectual, and reactions of any sort were practically nil. After a considerable period of time, however, reactions began to occur, which fortunately were of a local nature. Oral penicillin became available at that time, and I ceased the use of parenteral methods of administration. Since then, literally hundreds of courses of oral penicillin have been given to innumerable pa-

tients, and at no time has an adverse reaction been experienced. On the other hand, I have seen numerous patients with penicillin reactions who have been given the drug parenterally, which observation has made me conscious of the fact that parenteral administration of penicillin, under any circumstances, is a dubious procedure.

Numerous reports of reactions to oral penicillin have appeared in the literature and a careful search was made to ascertain whether or not anyone had reacted to oral penicillin without ever having had a dose administered parenterally. Amazingly there are practically no cases on record of patients having been sensitized by oral penicillin; in every instance a history of previous parenteral administration was revealed. In many reports, where the method of administration was not stated clearly, the authors of the articles were communicated with; and in not a single case did we fail to learn that the drug had been given parenterally previous to the reaction.

At the present time, certain procedures are suggested to determine the presence or absence of penicillin sensitivity; namely, skin and conjunctival tests. A few instances of severe reactions to both methods are on record, and at this writing, I have under my care one such case resulting from conjunctival testing. From the record, oral administration appears to be less hazardous from the standpoint of both sensitizing the patient and shocking the patient.

It is estimated that there are millions of peni-

cillin sensitive individuals, but as with the diminishment of horse serum sensitivity, if parenteral administration of penicillin is discontinued, eventually the incidence of sensitivity will undoubtedly wane. Following are what I consider some basic rules for the administration of penicillin.

Sensitivity tests should be done with any organism under consideration, in order to establish their responsiveness to specific antibiotics. The determination of the predominating organism is not adequate. The effects of an antibiotic upon the infecting organism is not a mathematical equation, but rather a biological phenomenon. The fact that a certain type of organism is supposed to respond to a given antibiotic is not an adequate determination of its effectiveness, in my opinion, because the rule does not always apply.

A patient might possibly give a positive history of previous sensitivity to penicillin, which might well be a contraindication to its use, particularly parenterally. The patient with no previous history of sensitivity will rarely, if ever, have a penicillin reaction to oral administration of the drug, however. It seems clear, after thorough consideration, that penicillin sensitivity results from parenteral administration, not from oral administration; however, if a patient has been sensitized parenterally and there is a history thereof, caution should be used in oral adminis-

tration. Its use should be a calculated risk, and the decision should be made by the attending physician, not based upon rule of thumb. It is estimated that penicillin given parenterally is five times more effectual than that given orally, although the basis of this opinion is not entirely clear. The difference in effectiveness, however, can be compensated for by increasing the oral dosage.

Because the presence of penicillin persists in the milk from cows treated with penicillin for mastitis, this aspect is receiving a great deal of attention. It would seem that the possibility of shocking a patient who is sensitive to penicillin cannot be ignored, but it would certainly be remote. The question has been raised as to whether or not the penicillin in milk would be sufficient to sensitize. Having searched the literature, I have found not a single reliable reference indicating sensitivity resulting from the ingestion of such milk.

Because of my interest in this subject, I would greatly appreciate being informed of any instances known to the readers concerning sensitivity to oral penicillin in patients who have never had it parenterally.—Howard M. Bubert, M.D., Medical Arts Building, Baltimore 1, Md.

Reprinted with permission from the *Maryland State Medical Journal*, Vol. 9, No. 11, Nov., 1960.

Editorial Notes . . .

The American Cancer Society, through its component societies, is conducting an epidemiological study of cancer. It is the largest statistical research of its kind and involves more than 1,100,000 persons in the United States. The study was started in 1959 and seeks to discover the correlations, if any, between environmental factors and cancer; 5262 people are the subjects of study in Marion County.

Recently the first annual follow-up was completed with a satisfactory contact with all but four persons. Of those followed 48 have died in the first year. Causes of death will be deter-

mined and integrated into the statistical information. The investigation was initiated by almost 400 volunteers who interviewed and distributed questionnaires to friends, family and acquaintances.

The study is to continue for 6 years. The next annual follow-up will broaden the inquiry by seeking still more specific information as to the possible relationship of air pollution and automotive exhaust fumes to lung cancer.

Speeding ambulances cause more deaths than they prevent. It seems that everyone

except doctors want ambulances to hurry. Recently the Howard County Medical Society issued a statement to point out that a hurried trip is almost never necessary and always introduces the risk of accidental collision with other vehicles with added danger to the patient and others involved. The Society recommended that ambulances drive within the posted speed limits and obey all traffic signs and lights except when on the way to an accident where serious bleeding might be considered a possibility.

Hospitals can provide menus "comparable to those of the finest restaurants" without exorbitant cost. So says an article in a recent issue of "*Hospitals*," *Journal of the American Hospital Association*. Mount Sinai Hospital in Chicago has pioneered in expanding its food service to include a wide selection of items. A popular selective menu is the basis of the system. The difference is the number of choices offered, and the inclusion of such goodies as rock cornish hen with wild rice and trout amandine.

Food costs have not gone up because the patients order only what they want and almost always eat all of it. Breakfast on a normal diet provides a choice of nine fruits and juices, nine entrees, several kinds of breadstuffs and beverages. Luncheon menu lists two soups, eight hot entrees, five cold entrees, 17 desserts, any fresh fruit in season and beverage. The plan also functions for modified diets and children's diets.

Americans spent the same number of days in the hospital—on the average—in 1959 as they did in 1940. Counting general, special, mental and tuberculosis hospitals, the annual use is now 2.8 days per person, exactly the same as in 1940. There was a peak of 3.9 days in 1945 due to the war, and an average of 3.1 days in 1951, '52 and '53, reason not given.

The Health Insurance Institute reports the use figures and also passes on the data on hospital admissions, which is still another thing. In 1940 there were 74 admissions per 1,000 population; in 1959, they recorded 130. Advances in medicine with consequent shorter hospital stays

make the difference. If people stayed as long as they did in 1940, the use figure would be 43% higher instead of the same, and no one would have enough hospitals.

It has been observed on numerous occasions that people from southern U. S. withstand Indiana summers better than the natives. Until recently it was not realized to what extent this was true. The *AMA Archives of Environmental Health* recently published results of an experiment on the efficiency with which men performed in heat and high humidity. Four young men from New England and five from southern Florida were tested during ordinary walking. "The study showed that the total thermal strain of walking at a rate of 3 or 3½ miles per hour was roughly 40% greater for the northerners than for the southerners at 79 degrees, and 70% greater at 84 degrees.

More news on "Vitamania." The National Retired Teachers Association and the American Association of Retired Persons operate a mail-order drug service in Washington, D. C. The *AARP News Bulletin* recently announced an offering of 16 different vitamin formulas, for sale by mail at economy prices. Within a month more than 4,000 orders were received.

Indiana is one of three states credited with the most effective enforcement of its food and drug laws. The *Journal* of the Louisiana State Medical Society in a discussion of "Exploitation of Patient with Arthritis" reviews the medical quackery and patent medicine racket being perpetrated on victims of arthritis. Misrepresented drugs, devices and treatment, to the number of over twelve hundred, with an annual cost in excess of \$250 million are mentioned as a measure of the size of the problem. The solution recommended is (1) the strongest possible legal controls, adequately enforced and (2) a public educated to recognize false claims and resist them. Indiana, California and Arkansas are named as the states with the best law enforcement in this regard.

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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K. O.: ANNALS OF ALLERGY 17:915, 1959.

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[†] PARABROMDYLAMINE MALEATE

Report of a Rheumatic Fever Survey

Rheumatic Fever Committee
Indiana Heart Association*

THE RHEUMATIC FEVER COMMITTEE of the Indiana Heart Association has recently completed a survey of Indiana physicians with respect to the number of patients under their care who had rheumatic heart disease or a valid history of rheumatic fever, and of these, how many were receiving treatment for the prevention of streptococcal diseases. The survey was conducted in cooperation with the Indiana State Board of Health.

Approximately 4,300 physicians received by mail the following questions:

1. How many patients are you personally following who need Rheumatic Fever prophylaxis?
2. How many of these received prophylaxis?
3. Which method of prophylaxis do you prefer for your patients?
Injectable once a month?
Daily Oral?
No preference?

Two thousand thirty-nine physicians replied. Of these, 1,100 said that the survey did not apply to their practices. Nine hundred thirty-nine replied as follows:

Patients requiring prophylaxis	-----	3,759
Patients receiving prophylaxis	-----	3,171
Patients without prophylaxis	-----	588

In answer to the question of which method of prophylaxis was preferred, the following data were obtained:

Injectable	-----	59%
Daily Oral	-----	25%
No preference	-----	11%
Varies with patient	-----	3%
No answer	-----	1%

* Dr. Richard M. Nay, Dr. Wendell C. Anderson, Dr. Robert Armer.

Two physicians replied that they considered prophylaxis to be of no value.

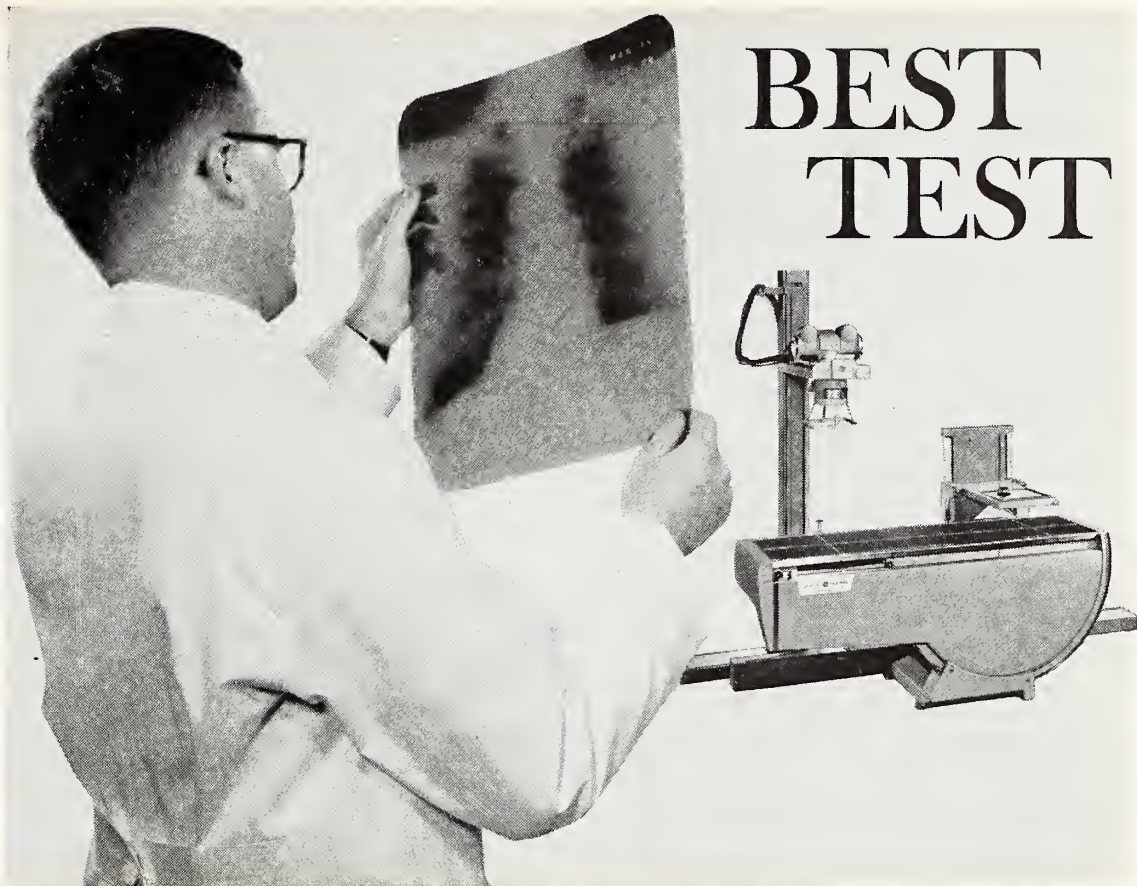
In addition to the request for information, the physicians were reminded that the Indiana State Board of Health has available to physicians intramuscular penicillin G for the prophylaxis of streptococcal diseases. This program had been recommended by the Rheumatic Fever Committee of the Indiana Heart Association and approved by the Indiana State Medical Association.

Prevention of Attacks

The committee believes it important to review the statements of the American Heart Association concerning the cause of rheumatic fever and the prevention of rheumatic fever and bacterial endocarditis through control of streptococcal infections. The initial and recurrent attacks of rheumatic fever are precipitated by infection with group A streptococci. Therefore, prevention of rheumatic fever and rheumatic heart disease depends upon the control of streptococcal infections. This may be accomplished by prevention of streptococcal infections in rheumatic subjects, and by early and adequate treatment of streptococcal infections in all individuals.

Bacterial endocarditis may result from dental and other surgical procedures and from obstetrical procedures in patients with rheumatic or congenital heart disease. When such procedures are undertaken, these patients should be protected by administration of antibiotics in therapeutic doses.

In both prevention and treatment of streptococcal infections, penicillin is preferred. For those patients who are sensitive to penicillin, sulfadiazine is recommended. For prophylaxis, benzathine penicillin G, 1,200,000 units given



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RHEUMATIC FEVER

Continued

intramuscularly once a month or 250 mgm of penicillin orally twice daily are preferred. If sulfadiazine is used, 0.5 to 1.0 gm once a day is satisfactory.

For the treatment of streptococcal infections: effective blood levels of penicillin should be maintained for a period of 10 days to prevent rheumatic fever by eradicating the streptococci from the throat. Intramuscular administration is preferred. One injection of benzathine penicillin G in the amount of 900,000 to 1,200,000 units is sufficient. If procaine penicillin is used, one injection of 600,000 units every third day for three doses is effective. When oral penicillin is used, 250 mgm three times a day for a full 10 days is necessary.

Among patients sensitive to penicillin, broad-spectrum antibiotics may be given in full dosage for 10 days. It should be noted that since sulfonamide drugs are not bactericidal, they will not eradicate streptococci and should not be used for the treatment of acute streptococcal infections.

It is recognized that despite optimal therapy, it is sometimes not possible to prevent rheumatic recurrences once streptococcal infections occur in a rheumatic subject. However, it is believed that the program of treatment and prevention of streptococcal infections is important and rewarding. ◀

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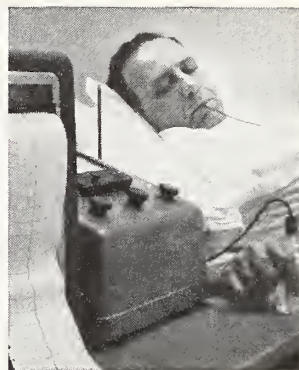
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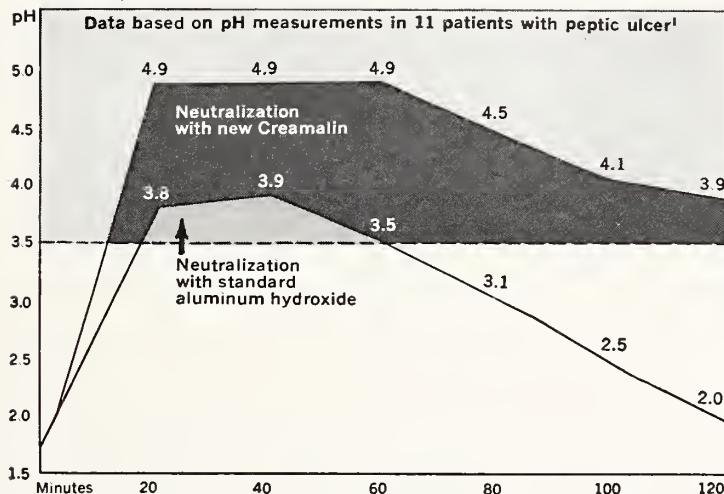
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: J. Am. Pharm. A. (Scient. Ed.) 48:384, July, 1959.

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The Approach Positive

A. W. CAVINS, M.D.

Terre Haute

Much criticism has been leveled at the medical profession for its alleged negative approach to those portions of the problem of medical care which have become political footballs. In regard to medical care for the aged, there has been a question in many minds as to why this subdivision should be essentially different from the problem as a whole, but there has been much propaganda to that effect.

An editorial in the Wisconsin Medical Journal, November, 1960, promotes ideas for a distinctly positive approach to the situation created by the Mills-Kerr Bill, and is well worth reading by Indiana doctors. It is quoted in part:

The Mills-Kerr Bill passed through both houses of Congress, propelled by post-convention pressure to do something about medical care for the aged. It took the place of the Javits plan, supported by Vice-President Nixon and the Republican administration, as well as the Democratic-sponsored attempt to incorporate medical care for the aged in the Social Security system.

As a compromise measure, the Mills-Kerr Bill walked a tightrope between both the Republican and Democratic platforms. But the interest of the public seemingly is better served by this result than an action calculated primarily to produce dramatic political benefit to either party.

* * * *

It is true that the Mills-Kerr Bill can be manipulated by willful individuals or state politics into an unrealistic scheme repugnant to the dignity of age. Similarly, because the expenditure of funds is geared to the states it is possible that some may dissipate their share of funds aimlessly and through local and state politics violate the intent of Congress. It is not hard to see how many aged persons who should receive medical care assistance might be deprived of it by a local determination as to eligibility or need.

But the Mills-Kerr Bill is probably no more open to these dire possibilities than many other federal-state matching programs. And, when all is said and done, the Mills-Kerr Bill can easily be the challenge that evokes a humane, professionally oriented, workable program that can form the model for subsequent legislation which is probably coming.

* * * *

The heart of the whole matter is to prevent medical indigency from occurring, except in rare circumstances and without imposing uncontrollable tax burdens, government regulation and control or harsh restrictions on choice of physician or hospital. Here is precisely where the supporters of Forand-type legislation miss the point.

By assuring each aged person of modest means of the availability of medical care when he needs it on a *prepaid* basis, many problems of the usual public assistance program can be avoided except in situations of extreme poverty. The sensible program, therefore, is to forestall the need for government-provided medical care.

This can be done by subsidizing, with Mills-Kerr bill funds, health insurance coverage of

a comprehensive nature for elderly persons in certain income levels. When the demand for medical care arises, it can be provided without concurrent consideration of status. The individual's contribution to the cost of his care—through deductibles or co-insurance features—can be negotiated ahead of time, and the aged would be able to face the need for medical care with the confidence that it is to be had on the same basis as other self-sustaining members of the community.

* * * *

Conditions in Wisconsin are uniquely ripe for an intelligent use of the Mills-Kerr Bill.

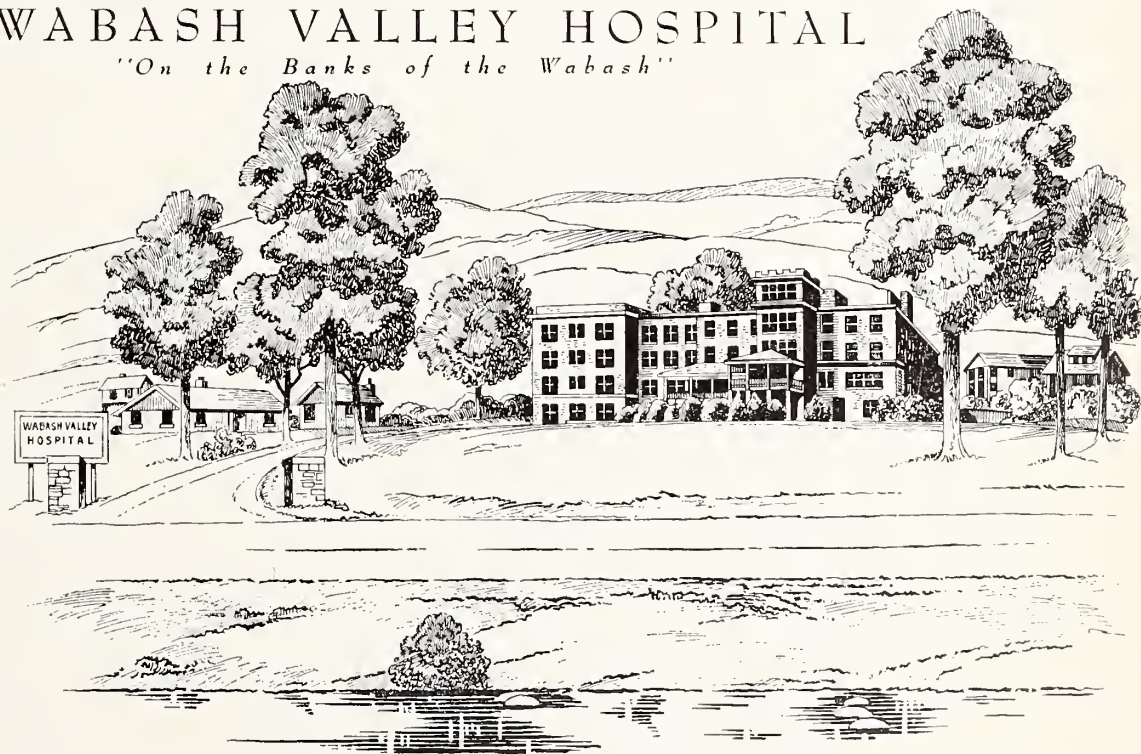
We have a progressive Public Welfare Department, we already provide comprehensive care for recipients of Old Age Assistance on a basis equaled only by two other states, and we have the insurance mechanisms already established to provide similar coverage to all elderly. Wisconsin has the opportunity to lead the nation in caring for its senior citizens, and it is an opportunity that must not be missed.

The supporters of all-out federal medical care are waiting for the states to fail with the Mills-Kerr Bill. Nothing could refute their arguments so well as Wisconsin's economical, intelligent use of existing legislation to provide comprehensive medical care for our aged.

Our purpose in reprinting these excerpts and in calling attention to the whole matter is well stated in the first sentence of the last paragraph above. Of course, Wisconsin must have company in the "intelligent use of existing legislation," and that is where we come in as a sister state. ◀

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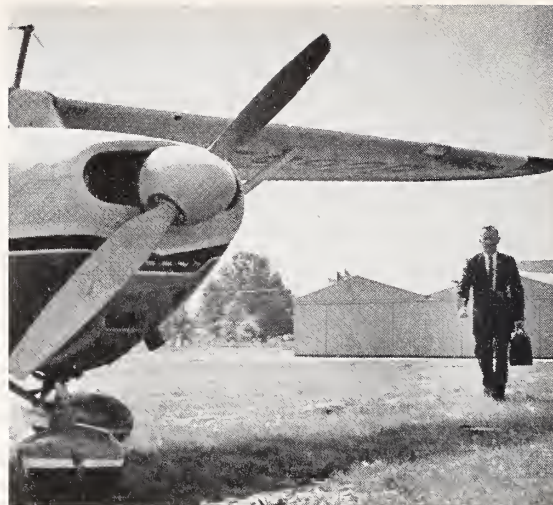
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Our Cover Story



"AT A MOMENT'S NOTICE"—Dr. Herschel Moss, Indianapolis, answers an alert.

Indiana's Flying Physicians— On Call for Quick Emergency Relief

AS THE CURRENT Civil War Centennial Celebration gathers momentum and medicine turns to commend, among others, the war services of old-fashioned "horse and buggy" physicians, it's hard to believe that 100 years later, up to 90 Indiana physicians could be at the scene of a major Hoosier disaster in less than two hours.

They would be members of the Flying Physicians—licensed pilots with small, privately-owned planes who make their services available to state and national civil defense programs under their own emergency plan.

The Indiana chapter is affiliated with the Flying Physicians Association, Inc., a group of some 2,000 physician-pilots from throughout the na-



DISCUSSING A RALLY FLIGHT with Nick Colbert of the State Aeronautics Commission (left) is Dr. Michael McGrath, Indianapolis.

tion. Dr. Frank H. Coble, Richmond, Ind., is national president.

Mobile Hospital Staffs Assured

Some 50 mobile hospitals are kept in storage throughout Indiana for civil defense emergencies. The Flying Physicians would be able to get into disaster areas with drugs and nurses and man these hospitals for quick relief until permanent facilities were organized.

These services cost nothing to the taxpayers—the physicians own and maintain their planes, and drug companies have pledged their cooperation in case of disaster. Such plans have recently proved their value in two disasters: the Yellowstone Park landslide, where a flying physician arrived first on the scene, and the Texas City oil blast.

Late last summer the Indiana chapter called a surprise alert—without warning, physicians were notified by local police of a mock disaster, and a representative group arrived at the Bloomington, Ind., airport within a few hours.

The emergency program itself has been in effect in Indiana for well over a year. Its latest feature is a standardized emergency kit which all planes would carry while on missions.

High Membership Qualifications

Membership qualifications are, of course, high. All doctors must be licensed pilots to join the organization, and are required to have some instrument training.

While readiness to cope with emergencies is one of the most dramatic aspects of the Flying Physicians' program, another important function is safety. They promote instrument training, weather recognition and advanced proficiency and knowledge.

Many of the doctors were pilots long before the Indiana group was organized in 1959. They use planes frequently in their practice. Dr. Michael McGrath, who heads the Indianapolis area group, points out that Flying Physicians aren't



DR. AND MRS. FRANK COBLE, Richmond, load their plane and prepare to attend a national FPA meeting.

"FLY-INS" are scheduled several times a year. This one, at South Bend, featured Mr. Frank Barton, AMA, as special speaker.



Medical Disaster Preparedness—The AMA Role

FRANK W. BARTON*

AMA Headquarters

CIVIL DEFENSE is like so many distasteful tasks which we face daily. It is less distasteful when we discuss the role of someone other than ourselves. As physicians, you have a clear responsibility to provide medical and health services in time of a disaster. As members of the Flying Physicians Association, you have a mobile resource to cope with disaster situations.

What is wrong with civil defense today? Let's review some of the basic facts and problems to see if we can reach some understanding of the subject.

When civil defense is mentioned most people naturally think in terms of an all-out nuclear war with millions of casualties. This produces an awesome and overwhelming picture. People view the problem as hopeless; to the average individual it is beyond solution, so nothing can be done. The result is that very little is being done in civil defense preparation, particularly on an individual basis.

Actually, many other types of disaster daily threaten our civil way of life. In December 1958, a school fire disaster struck in Chicago causing 95 deaths and several hundred children casualties. Three months later a tornado swooped into St. Louis leaving in its wake several fatalities, 300 casualties and extensive property damage. The New York City blackout, the Yellowstone National Park earthquake and the Pennsylvania turnpike snowstorm were disaster situations which required emergency action to save and protect life and property.

* Presented at a meeting of the Indiana Chapter, Flying Physicians Association, South Bend, Ind., Nov. 1, 1959. Mr. Barton is Secretary, Council on National Defense, American Medical Association.

Disaster Preparedness and Protection

The essential difference between these natural disasters and a war-producing disaster is merely a matter of degree. Now this is nothing new to us. We just don't put enough emphasis on this point. Civil defense must be recognized and publicized as a system of preparedness and a method of affording protection in all types of disaster situations such as fire, tornadoes, earthquakes, floods and, of course, enemy attack. Let's start recognizing civil defense for what it stands for. Civil defense is the preparation for and the carrying out of emergency operations to cope with all kinds of disasters, including protection and survival in an all-out war.

In some ways we are a contradictory race. We constantly strive for more and better security and protection for ourselves and our families. We purchase health, life and all kinds of insurance. We build retirement programs and have our nest eggs for a rainy day.

On the other hand, some of our attitudes or lack of foresight are downright deplorable. Public attitude toward civil defense is reflected in part by the amount of money we are willing to spend for local protection and preparation. According to a survey which was publicized, the per capita expenditure for civil defense in Philadelphia last year was six cents or the cost of a package of chewing gum. New York City spent about 18 cents per capita in 1958 on civil defense—a lot less than the cost of a pack of cigarettes. I don't have to use civil defense as an example of our indifference or lack of common sense planning. Let me cite a more timely and pathetic case.

For years scientists labored diligently to find a way to eradicate poliomyelitis and we all

contributed generously to down this dreaded disease. At last we were successful—the Salk vaccine was discovered and became available in April 1955. It was then a simple matter to overcome polio—get everybody vaccinated, particularly the children.

Apathy Provokes Polio Increase

But look at what happened. As of August 28, 1959, more than half of the population of the United States (52%) had not received a single injection of the Salk vaccine. Only 45% of the children four years of age and younger and only 60% between four and 20 years of age have received three injections of the polio vaccine. Major outbreaks of polio occurred this year in Kansas City and Des Moines. During the first 33 weeks of 1959, a total of 3,426 polio cases were reported by the U. S. Public Health Service as compared with 1,638 cases for the entire year of 1958. Of 1,446 paralytic cases, whose vaccination status is known, investigation has shown that 83.7% were unvaccinated or partially vaccinated.

This is the polio picture in spite of all the attendant publicity given to the immunization program. Does it take an outbreak of polio to force a community to undertake an immunization program that it should have done several years earlier? Does a community have to suffer a disaster before it will heed the warning to prepare itself for such situations?

FLYING PHYSICIANS

Continued

"playboys." They maintain their interest because it provides fast transportation and insurance in case of disaster. Planes last longer than automobiles, cost not much more, are cheaper to operate and save the doctor's time on the road.

The group meets to discuss business matters and further coordinate plans several times a year. "Fly-ins" take place at various Indiana airports, where members, their families and nurses join for programs and meetings.

Realizing that the future of the world is "in the air," the flying doctors at these gatherings show their interest in aviation safety promotion, seek ways to stimulate acceptance of aviation and to encourage aviation activities and interest among the medical ranks. ◀

The enigma of civil defense is a real puzzler. It would be idle for me to even attempt to single out the biggest problems of civil defense. I do know that it is next to impossible to motivate people for civil defense preparedness. All of us know that a basement shelter, an emergency supply of food, water and other daily necessities, and first-aid training offer an individual and his family a good degree of protection in a disaster. Still, very few people will take the time to institute these simple precautions. Somehow or other, we have failed to fear the results of a nuclear war.

A recent news item reported that a sociologist was asked to help suggest the best possible courses for the Scientific Age. His answer: look to the Stone Age. The most basic course, he said solemnly last week in his school's alumni newsletter should be "introductory survival technology." Suggested items included how to make a corn meal, simple traps, tan leather, make simple tools and weapons from stone, smelt ore, find safe drinking water, recognize poisonous plants, keep an infant alive without milk. We can all think of a lot more "how-to-do" items. He summed up his suggestions as follows: "A plainly pessimistic but utterly realistic course designed to keep at least a few of our most intelligent people alive for as long as possible following an all-out war."

Need for Educating Public

Education is an important element in an effective civil defense effort. There is a great need for a down-to-earth point of view and approach to civil defense. The American population must be informed as to how they can help themselves and others in the event of an emergency. This is obvious because enough physicians and other medical and health personnel just won't be available. There must be planning and preparation in advance because well organized protective measures cannot be formulated and placed in operation after a disaster strikes. Every individual should be taught in advance the civil defense knowledge, skills and fundamentals needed for an emergency such as a disaster.

How is Russia solving its civil defense problems? The Military Operations Subcommittee of the House of Representatives made a study and report on this subject and it might startle

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“nutrition...present as a modifying or complicating factor in nearly every illness or disease state”¹

1. Youmans, J. B.: *Am. J. Med.* 25:659 (Nov.) 1958

cardiac diseases “Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease.”²

2. Kampmeier, R. H.: *Am. J. Med.* 25:662 (Nov.) 1958.

arthritis “It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . .”³

3. Fernandez-Herlihy, L.: *Lahey Clinic Bull.* 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.⁴ Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.⁵

4. Sebrell, W. H.: *Am. J. Med.* 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: *Therapeutic Nutrition*, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases “Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult.”⁶

6. Overholser, W., and Fong, T. C. C. In Stieglitz, E. J.: *Geriatric Medicine*, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.⁷

7. Goldsmith, G. A.: *Conference on Vitamin C*. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: *Medical Science* 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.⁸ “Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes.”⁹

8. Duncan, G. G.: *Diseases of Metabolism* 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: *Am. J. Med.* 25:708 (Nov.) 1958.

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DISASTER

Continued

you to know exactly what has and is being done in Russia.

All Soviets Given Course

According to this congressional report, in the summer of 1955 a vast formal program was undertaken to train the entire Soviet population in the fundamentals of atomic defense. A 10-hour course was developed and the entire adult population of the Soviet Union was called upon to complete the course by the end of 1956. If Soviet claims are to be accepted, over 85% of the Russian people completed the course.

In 1958, a second Soviet course of 22 hours was launched and again taught to the Russian population on a compulsory basis. This program included training with gas masks in the presence of real poison gas. A third course has already been started and a fourth course will apparently be undertaken during 1959 or 1960. A program for school children will also begin in the fall of this year.

What does all this mean? The report sums it up by saying, "The scope and intensity of this mass training program probably means that more people have learned the fundamentals of civil defense in the Soviet Union than in any other country."

Russia also has its civil defense problems. In June 1958, a Russian journal reported: "Unfortunately, a certain part of the population (an insignificant part, it is true) still has not gotten over the backward attitude that there is supposedly no escape from the atomic bomb, and that therefore allegedly there is no point in studying in civil defense classes."

The medical profession has a great responsibility for educating and training the public for civil defense readiness, particularly the emergency medical and health aspects for survival. Dr. Alphonse McMahon of St. Louis, in an address before the Section on Military Medicine at the AMA Meeting at Atlantic City in June 1959, put it this way: "As civilian physicians, then, we must extend our effectiveness in times of community disaster by developing and training paramedical personnel, as has been done in the military." Dr. McMahon continued as follows: "To accomplish this, each physician should, in his own neighborhood or community, make

it his personal responsibility to assemble and to train a group of persons in the fundamentals of first aid and survival procedures. At the same time the physician, broadening his scope of activities beyond his own limiting professional activities, should coordinate the activities of nurses, paramedical personnel, rescue workers, ambulance drivers and hospital personnel in order to form an effective medical team. In times of disaster, these would be his immediate assistants; in preparation for disaster, they would also serve by instructing the rest of the community in the fundamentals of first aid."

"Whether physicians are motivated to action by patriotism, love of humanity, upholding their professional oath, or just plain down-to-earth self preservation," according to Dr. McMahon, "they cannot avoid their responsibilities in these matters, for they are the reservoirs of the medical knowledge necessary to be imparted."

Physicians Obligated in Disaster

You know and I know that the medical profession—each physician—has the responsibility and obligation for medical disaster preparedness. This burden is yours and yours alone. The people in your community look to you and expect you to take care of their emergency medical needs—and they have a right to expect you to be prepared. England's Prime Minister Disraeli once said, "I am prepared for the worst but hope for the best." Every physician should use this motto as his goal for medical disaster preparedness.

I have purposely discussed your responsibilities first because the success of the AMA program depends on you as individual physicians. The success of planning on the national and state levels is directly geared to your capability for effective local action.

The Association recently completed a special study project and submitted it to the Office of Civil and Defense Mobilization. The report was prepared for and at the request of the OCDM. The Association formally acknowledged the challenging, but vital, need and urgency for a nationwide civil defense health and medical care program.

The role of the AMA is to prepare its members to cope effectively with the results of a mass attack on the United States and to assist actively in preparing the nation to withstand such an attack. In the event of a mass attack



After a history and a physical ruled out organic disease, the physician diagnosed the case as recurring states of anxiety. To relieve these symptoms for this busy, on-the-go housewife, he prescribes Meprospan-400, the *only* meprobamate in *sustained-release* form.



As directed, the patient takes one Meprospan-400 capsule at breakfast. Her symptoms of tension and nervousness are soon relieved, and she will not have to remember to take another capsule until dinnertime.



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DISASTER

Continued

on this country, the role of the medical profession is to provide to the nation the highest quality and best organized curative and preventive medical services possible in order that maximum numbers of physically and mentally fit survivors are and will become available to assume their share of responsibility in the ensuing national recovery efforts and to participate in concurrent and subsequent operations.

Urge Society Committees

The Association, through its Council on National Defense and its Committee on Disaster Medical Care, plans to accelerate its efforts to stimulate interest and activity in civil defense at the state and county medical society level. Several years ago, the Council urged state societies to set up Committees on Emergency Medical Care. Practically all of the states now have such committees. We hope to maintain a closer contact with these state committees and furnish them the guidance and assistance necessary to their effective operation.

There are many things to do in order to accomplish this objective. We are encouraging the publication in *JAMA* of more articles devoted to the scientific aspects of medical disaster preparedness. We want to encourage a similar action so that more medical disaster preparedness material may be published in the state journals.

The Council sponsors two yearly conferences dealing with medical civil defense problems and plans. We have urged state and local groups to also sponsor similar conferences and symposiums. We must get more of the state societies to include disaster medical care in the programs of their annual sessions.

We are exploring the possibility of maintaining a list of speakers on disaster medical care topics and the establishment of a film library of appropriate films for the use of state and county medical societies. We feel that this is a simple method to assist state and local groups in the planning of programs. There is a possibility that we may inaugurate a one-day institute to acquaint representatives of state medical societies on recent developments in civil defense and disaster medical care.

The Association's assistance to individual physicians includes answering of specific questions

on medical civil defense, furnishing of pertinent publications and materials on civil defense affairs and other means to interest, educate and train the profession.

The Association will continue to maintain an effective liaison with the Office of Civil and Defense Mobilization and with other national, medical and health organizations such as the American College of Surgeons, the American Public Health Association and the dental, nursing and veterinarian professions.

With the delegation of emergency medical and health service by the OCDM to the U. S. Public Health Service, there will be a requirement of close coordination and mutual understanding between the state and county medical societies and the Public Health Service officials charged with the federal responsibility of the disaster medical and health services. The AMA Committee on Disaster Medical Care is working closely with the Public Health Service in this field. For example, the Public Health Service is currently working on a project known as Self Help. Self Help involves the problem of imparting health information to the public for use in a post-attack period where medical service may not be available. Medical services of the Armed Forces have inaugurated self-help or buddy-aid programs designed to teach nonmedical personnel the rudiments of self-aid. Similar training for the general public may save many thousands of lives. Progress reports on the PHS project have been made to the Committee on Disaster Medical Care and the Committee will continue to assist in the formation and subsequent implementation of the program.

It is essential that every effort be made to bring local civil defense organizations to such a state of readiness that the medical and health units can immediately and effectively function when called. The AMA is willing to provide the leadership and guidance to help you with the local and state medical disaster preparedness programs. The ultimate discharge of these responsibilities rests with the practicing physician and his local medical society. ◀

While he was blaspheming, the farmer opened the front door. For a moment he listened in awe and amazement. "Well, I'll be durned, Doc," he drawled finally. "I never knowed before that them Hippocratic Oaths you fellers go in fer was so much like the ones us laymen use."—*J.A.M.A.*, reprinted in *Quate* Vol. 40, No. 13.



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Medicine
At
Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Jury to Determine Liability of Attending Surgeon for Negligence of Resident Surgeon—A hospital which had been sued for the negligence of a resident surgeon filed a third party complaint against the attending surgeon. The attending surgeon in turn filed a motion to dismiss. But the Supreme Court of Nassau County, N. Y., ruled that since the evidence could result in a jury question as to whether the staff physician was only passively negligent while the attending surgeon was actively negligent, the third party complaint could not be dismissed.

The plaintiff in this action, alleged that her laryngeal nerves were severed and injured during the course of a thyroidectomy performed by the resident staff doctor. She claimed that the hospital was liable for his negligence under the doctrine of respondeat superior. —*Hollant v. North Shore Hospital, Inc.*, 206 N.Y.S. 2d 177 (N.Y., Aug. 5, 1960).

Liability of Others for the Hazardous Propensities of a Patient Must Be Predicated Upon Their Knowledge of the Patient's Dangerous Condition—A practical nurse in a nursing home brought suit against a patient's daughter and a doctor who had previously treated the patient. She alleged that the patient had assaulted her and that the defendants were negligent in failing to warn her of the patient's hazardous propensities.

The Supreme Court of Queens County, N. Y., held that "since actual knowledge of the patient's dangerous condition is essential for recovery . . . and the plaintiff has not adduced a scintilla of evidence thereof" her complaint

should be dismissed.—*Scaley v. Finkelstein*, 206 N.Y.S. 2d 512 (N.Y., Aug. 11, 1960).

Statute of Limitations of State Where Alleged Malpractice Occurs Controls, Rather Than Laws of State Where Malpractice is Discovered—The plaintiff had had an appendectomy performed by the defendant physician in New York. Five years later in California, she discovered that a sponge had been left in her abdomen. She sued the defendant in New York and contended that the California statute of limitations should be controlling. In California the statute runs from the time the injury is discovered or by reasonable diligence should have been discovered. But in New York a malpractice action must be filed within two years of the time of the negligent act.

The Supreme Court of New York County held that the New York law rather than the California law governed. And, accordingly, the court dismissed the action.—*Dorfman v. Schoenfeld*, 203 N. Y. S. 2d 955 (N. Y., March 10, 1960).

Sufficient X-Rays Jury Question

Conflicting Testimony on Whether Physician Took Sufficient X-Rays Jury Question—The plaintiff alleged that the defendant physician, by taking only one x-ray film of his left knee, failed to exercise reasonable care and diligence in diagnosing his difficulty. Further, he claimed the defendant failed to apply the correct treatment. As a result, the plaintiff alleged that he suffered permanent injury to his knee.

It was agreed that in diagnosing the plaintiff's ailment, it was the duty of the physician to take at least two x-rays, i.e., an A.P. view and a



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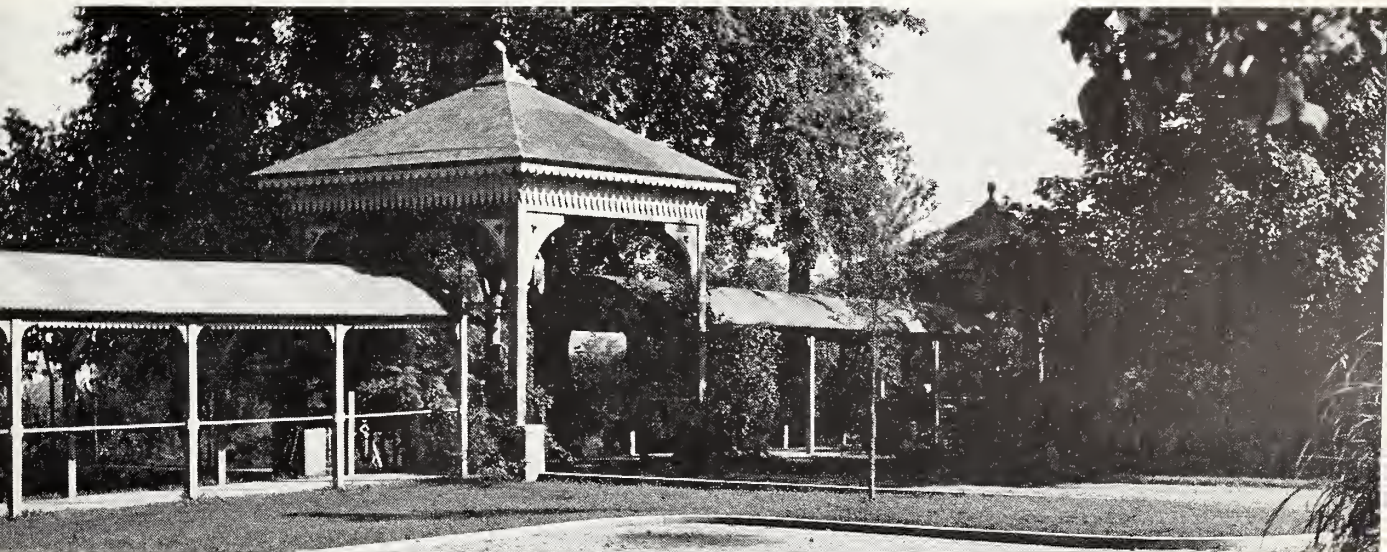
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AT LAW

Continued

lateral view. The physician testified that he took "one x-ray film which consisted of two views, an A.P. which is a view from front to back and a lateral view which is a view from side to side." But the plaintiff testified that the defendant's assistant took only one x-ray.

The court held that because there was a "genuine issue of material fact a summary final judgment should not have been entered."—*Olschefskey v. Fischer*, 123 So. 2d 751 (Fla., Nov. 15, 1960).

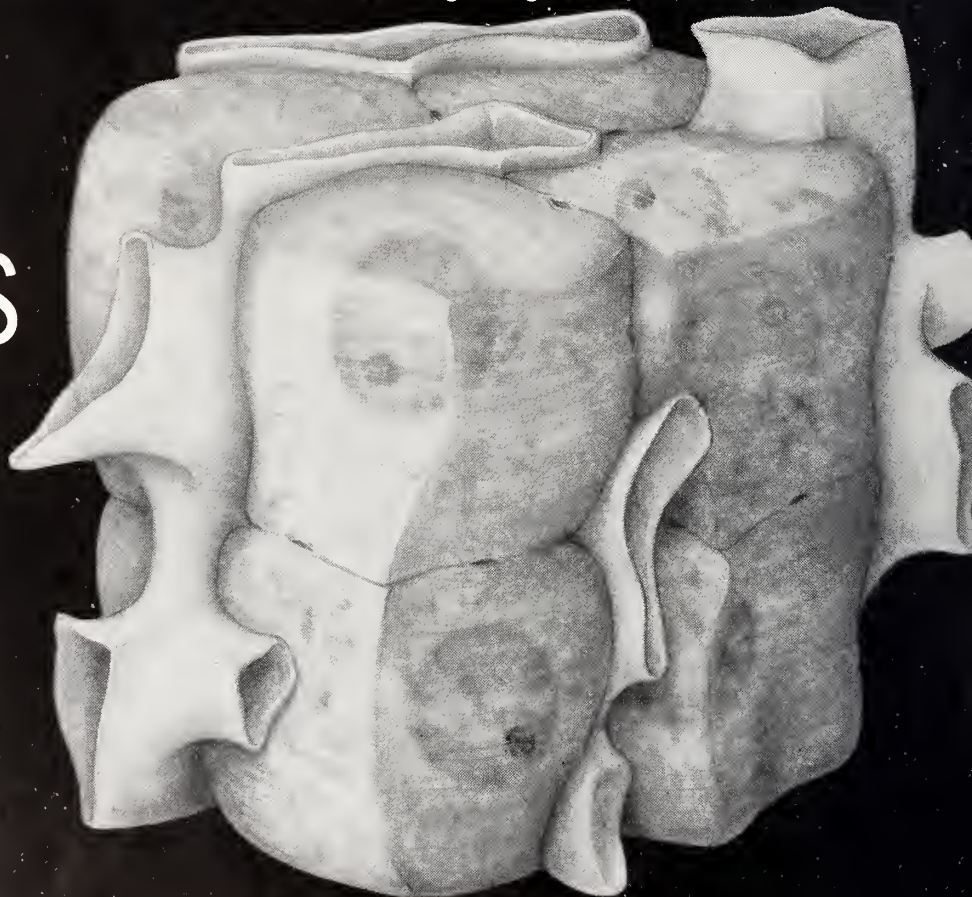
Lawsuit Filed for Death Following Administration of Drug—Breach of Implied Warranty and Lack of Informed Consent Alleged—On Nov. 29, 1960, Mr. and Mrs. Edgar F. Elfstrom of Fullerton, Calif., filed a complaint, seeking \$250,000 damages in the Superior Court in Los Angeles for the death of their 19-year-old daughter. They allege that she died of aplastic anemia following the administration of Chloromycetin, an antibiotic. The claim that this drug was given their daughter, who was a sophomore

at the University of Southern California, by the medical staff of the university after she complained of pain in her lower back.

The complaint charges wrongful death, malpractice and breach of warranty.

It is claimed that the defendants "negligently failed to warn" the plaintiffs or their daughter "of the dangerous and untoward consequences and hazards involved in the administration of the medicine or drugs which they intended to, and did use" in treating the patient. In addition, it is charged that no "free or informed" consent to the treatment was obtained and the defendants breached an implied warranty "that said medicine or drugs was, or were, of merchantable quality" and "reasonably fit for the purpose intended . . . the relief of a minor infection or pain." Named as defendants in the action are: Parke Davis & Co., manufacturer of the drug; The University of Southern California; three physicians who treated the girl; and 40 John Does.—*Elfstrom v. Parke Davis & Co., et al.*, Superior Court of Los Angeles (Nov. 29, 1960).

Three-dimensional drawing showing microscopic view of hepatic cells.



what
goes
on
in the
liver?

A multitude of physiological processes . . .

Motorist Can Request Own Doctor

Motorist Has Right to Have Own Doctor Obtain a Sample of His Blood—A motorist in Los Angeles who was charged with drunken driving requested that his own doctor be called at his own expense. He explained that he wanted his doctor to witness the blood test and obtain a sample of his blood. The request was denied.

The Appellate Department of the Los Angeles Superior Court held:

"We . . . hold that it was error to deny the defendant a reasonable opportunity to call a doctor of his own choice and at his own expense to give him a blood test at a time when he was suspected of being under the influence of intoxicating liquor. . . . This right of a defendant does not prevent the police from making their own test of the defendant's blood even before the arrival of defendant's doctor."

Accordingly, the court ordered the action to

be dismissed.—*People v. Dawson*, Los Angeles Superior Court, Appellate Department, Crim. No. A-4403, Trial Court No. M-15884 (Aug. 19, 1960).

Not Guilty Verdict Rendered Where Patient Alleged Operation Performed Without Consent—The plaintiff, age 60, alleged he entered the defendant hospital, pursuant to the recommendation of the head of the urology department, for an examination and observation, only. Instead, without his written consent, a resectoscope urinary operation was performed. Four additional corrective operations followed to help the healing. The first two were performed without his consent. Later he had three more operations at another hospital. He admitted the results of the eight operations were good.

He brought a malpractice suit against the first hospital and two physicians, charging that the operation had been performed without his consent. The jury returned a not guilty verdict.—*Johnson v. Presbyterian Hospital, et al.*, Circuit Court of Cook County, 53C-8983 (Nov. 17, 1960). ◀

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Indianapolis

Neuropathy, Rheumatoid Arthritis and Steroids

The occurrence of neuropathy associated with rheumatoid arthritis is presented by Hart and Golding,¹ in a larger series, to substantiate this finding, as stressed by Hart in 1957. They present 42 patients with this complication. Some attention has been paid to this association in the United States, but much of this work has attempted to incriminate steroid therapy as a causative agent. In the present paper, however, 12 of the patients had never been on a steroid therapy, and 15 others had received no steroids for the three years preceding the onset of the neuropathy. Nor did Butazolidin or gold therapy apparently play any role in precipitating the neuropathy.

Motor weakness occurred in 18 of the cases, and marked weakness or absence of dorsiflexion of the foot was the best guide as to definite onset. Sensory loss varied, but was most marked in the cases with motor involvement. Decreased ankle jerks was a fairly frequent finding. Twenty-six patients had symmetrical involvement, and 16 had asymmetrical. Although the onset was insidious in the majority of the cases, 13 patients had an onset acute enough for them to be able to state the precise date on which the symptoms began. The most common presenting complaints were numbness or burning, usually in the toes and feet. The incidence was higher in males than would be expected in this disease, known to have a higher incidence in females. No form of therapy has been found effective, and the onset of neuropathy should be regarded as a serious complication, and, in general, a poor prognostic sign.

Two further articles touch on this same problem. Steinberg² reports on 18 cases of neuropathy

with rheumatoid arthritis. However, he states that 15 of these cases had received ACTH or other steroids, and that in 10 patients there seemed to be a direct association between this therapy and the onset of the neuropathy. Again there was a higher incidence in males than would be expected. Symptomatology, signs, mode of onset and unresponsiveness to treatment seemed to agree with the earlier article. This author seemed to place more emphasis on the etiology being an arteritis than Hart was willing to admit. Again the seriousness of this complication is stressed.

Kibler and Rose³ deal with neuropathy in the "collagen diseases" in general, with attention to periarteritis and disseminated lupus erythematosus as well as rheumatoid arthritis. Generally this is not found in patients with scleroderma or dermatomyositis. In general, they feel that neuropathy in the various cases is resultant from arthritis, although they admit that the issue is still in doubt in rheumatoid arthritis.

Anorexia Nervosa

The frustrating problem of treatment of anorexia nervosa is presented by Dally and Sargent,⁴ who explain a new approach to therapy. They report on 20 patients treated over the past three years, using a program of insulin and chlorpromazine. This group is compared with a group of 24 similar patients treated by other means over the past 20 years. Their diagnostic criteria were (1) refusal to eat, with or without anorexia at the start; (2) severe loss of weight; (3) absence of evidence of schizophrenia, severe depression, or organic disease; and (4) amenorrhea of at least three months' duration in female patients.

Chlorpromazine was started at 150 mg per day, and increased in 75 mg increments, to tol-

erance. Insulin was given, starting with 5 units the first day, and increasing until sweating and drowsiness occurred. The diet is light at first; starting with 1500 calories, and increasing to 4000 calories. Therapy is gradually withdrawn as the patient shows improvement. Modified insulin was used. The average weight gain by the present method was almost twice that reported by other forms of treatment, and the duration of time required for treatment in the hospital was much shorter. The long-term follow-up on these patients also showed a better record. The authors feel that this is the most successful mode of therapy reported to date, and that the combination of modified insulin and chlorpromazine is much better than either agent used by itself. No deep psychotherapy is attempted during the course of treatment, but only good supportive care is given.

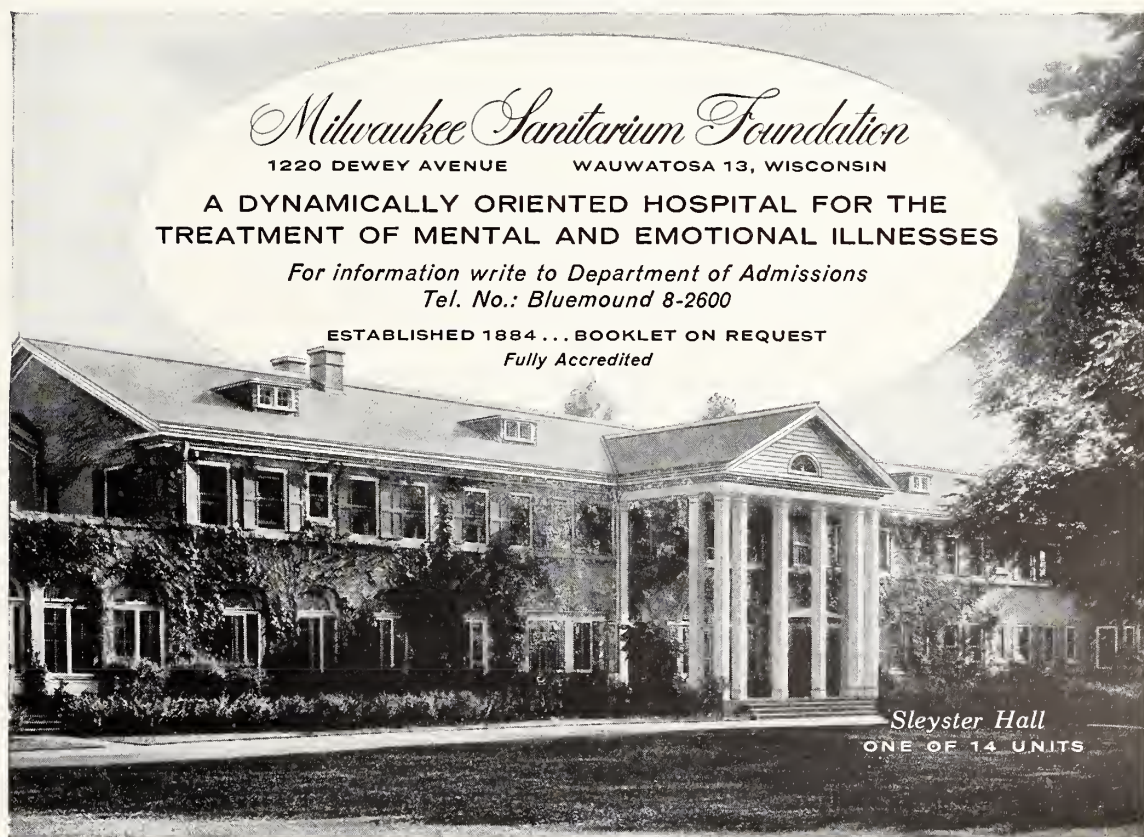
Abnormal Chromosomes

With the current rash of findings of abnormal chromosomal sex patterns in a wide variety of conditions such as Klinefelter's syndrome and Turner's syndrome, the report of Cowie, Cop-

pen and Norman⁵ is at least refreshing. These investigators measured biacromial and bi-iliac diameters on 100 male and 100 female patients with chronic schizophrenia, and then determined nuclear sex patterns on the patients. Although they confirmed the "narrowness" of schizophrenics as compared with normals, by these measurements, they were unable to demonstrate any abnormality of chromosomal sex pattern in the schizophrenics tested.

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ABSTRACTS

BOOK REVIEWS

THE CENTRAL NERVOUS SYSTEM AND BEHAVIOR

Mary A. B. Brazier, Ph.D., editor; Transactions of the Second Conference, Feb. 1959. The Josiah Macy Jr. Foundation. New York; 358 pages; illustrated; \$4.75.

This volume of the Second Conference on the Central Nervous System is a worthy successor to the one issued last year when the results of the first conference were presented. The same high standards continue to be met so that the reader finds rewarding material in every chapter and almost on every page. It is most interesting to observe how the extreme Pavlovian concepts of the Russians are converging with much Western Freudian material and they both are not only finding common ground but actually are beginning to fuse into a common whole. In line with the development of chemistry and bio-physics, the discussions are more and more on the biochemical level.

Dr. Bures of Czechoslovakia in particular emphasizes the Pavlov statement that "the brain, which creates science, itself becomes the object of scientific research and . . . the scientific attempts to overcome the philosophical boundary between the objective and subjective are fascinating but very difficult problems."

Well worthy of thorough study is the colored plate, Figure 58, illustrating regional differences in zinc-dithizone complex formation in Ammon's horn. The discussion on their meaning illuminates the very frontiers of the research going on in various laboratories of the world.

When the assembled scholars go to analyzing EEG Studies and Conditioned Reflexes in Man, there is recorded the most animated and yet—shall I say, obfuscating?—exchange of thoughts that I have had the pleasure of reading in a long time. The question of functional systems and centers was raised; the difficulty of expressing transactions of interdependent systems in linear cause-and-effect sentences was emphasized; the name of Descartes was invoked by Livingston of Bethesda, Md.; Engles was quoted by Bures—and the pundits were off into pachydermic ponderosities that truly delighted me even if I lack totally the capacity for the cooling caustics for which my late chief, Prof. A. J. Carlson, was so famous.

The entire record there for many pages should be read in order to get the full flavor of the discourse. After awhile, stochastic hermeneutics, conjectural exegesis, flowed naturally from the fact that "human beings are governed also by social laws characteristic of another stage of the development of movement of matter." Human psychology must be explained both from the physiological and the total social complex of interactions.

What is consciousness? Then, what is "higher" vs. "lower" levels of brain activity? Is not unconditioned behavior at least as complex as the various conditioned models set up by the experimentalists? The Cartesian and Aristotelian philosophies are spun out by even the gentlemen from the lands of diamat, dialectic materialism, until I could almost believe I was reading Carthusian discourses on immanence and Arianism. The summation by Galambos, starting on p. 301, is beautifully done—positively exhilarating, if a prosaic reviewer may be permitted such a term.

All in all, the volume is delightfully and educationally thought provoking and stimulating for all students in the fields of neurology, psychiatry and just plain, everyday practice of good medicine; it can be recommended without any reservations whatever.

Arnold Lieberman, M.D., New York, N. Y.

BIOLOGICAL ASPECTS OF CANCER

Julian Huxley, Harcourt, Brace & Co., New York, pp. 156, \$3.75. 1958.

Dr. Huxley is a distinguished scion of a great scientific family; he is an internationally renowned biologist and writer. However, in my opinion, this expanded version of the article from *Biological Reviews* is one of his less felicitous efforts. He gives the impression of having read the literature without having quite digested it. As a result, Dr. Huxley tends to merely summarize without emphasizing any one point as against another; the hopeful reader is left still bewildered.

To add to the confusion, Prof. Huxley has the disconcerting penchant for using well-known terms according to his own definitions which are tossed in haphazardly. "Viroids," "naked genes" may become "paragenes" without any warning! "Induction," "evocation," "competence," "individuation," "epigenetics" are not always used in the same semantic terms; a glossary with a page of neatly indexed definitions would be most helpful.

Without being too heretical, I can sum up by saying that this little monograph is (in my opinion) too elementary for the expert and too vague for the physician wanting a quick, readable scanning of the stated topic. Cancer, indeed, is "far from being a field of purely medical concern." However, there are extant clearer and more balanced presentations of the tremendous subject, cancer.

Arnold Lieberman, M.D., New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

ACUTE UPPER GASTROINTESTINAL HEMORRHAGE

Acute upper gastrointestinal hemorrhage in patients 65 years or older is rarely caused by a malignant lesion. Mild (10 gm Hgb. or more) or severe (7.1 to 10 gm) hemorrhage should be treated ini-

Aristocort

Triamcinolone has long since proved its unsurpassed efficacy and relative safety in the therapy of *rheumatoid arthritis, inflammatory and allergic dermatoses, bronchial asthma*, and all other conditions in which corticosteroids are indicated. But ARISTOCORT has also opened up new areas of therapy for selected patients who otherwise could not be given corticosteroids. Medicine is now in an era of "special-purpose" steroids.¹

One outstanding advantage of triamcinolone is that it rarely produces edema and sodium retention.^{1,2}

The clinical importance of this property cannot be overemphasized in treating certain types of patients. McGavack and associates³ have reported the beneficial results with ARISTOCORT in patients with existing or impending cardiac failure, and those with obesity associated with lymphedema. Triamcinolone, in contrast to most other steroids, is not contraindicated in the presence of edema or impending cardiac decompensation.³

Hollander¹ points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying

degrees. And McGavack,² in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.²

References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).



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Army Consolidates Medical Fitness Standards

A new Army Regulation which codifies and updates all directives and regulations on medical fitness is being published, the Department of Army has announced.

Army Regulation 40-501, "Standards of Medical Fitness," establishes uniform criteria for determining medical fitness of men and women for military service.

Revised standards are expected to result in a slight increase in rejections of individuals being considered for military service. However, the rise probably will be offset by a concurrent reduction in the number of individuals separated for medical reasons during the early phase of their military service.

Detailed standards for partial and total mobilization are set forth for the first time. The regulation also contains an important policy change on geographical and area assignment limitations

—a change that reflects the Army's need for more individuals who are medically adaptable to varied geographical areas.

Standards previously expressed in terms of acceptable and unacceptable medical conditions and physical defects are stated now simply in terms of unacceptability for military service.

The eight-chapter regulation, to be published in two increments, supersedes four current medical fitness regulations and various directives containing medical fitness standards.

Chapters 3 and 8 became effective Jan. 15, 1961. Chapter 3 deals with standards for retention of military personnel in the Army, promotion and separation, including retirement. Chapter 8 contains criteria for accepting doctors and dentists as Reserve officers if they are liable for military service.

Chapters 1 (General Provisions), 2 (Procurement Medical Standards), 4 (Flying Duty Medical Standards), 5 (U. S. Military Academy Medical Standards), will be published early in 1961 with a projected effective date of March 1, 1961.

In the future four additional chapters will be published on physical profiling and the scope, technic and recording of medical examinations.

The new regulation reflects advances and changes in medicine and warfare and views the individual as a whole man—in terms of his total medical, mental and physical capability to satisfactorily perform military duty.

The standards are designed to adjust medical fitness criteria to current Army needs while allowing the Army to utilize individuals with highly technical skills and high mental ability.

East-side residents of Indianapolis recently honored Dr. Walter F. Kelley on his 87th birthday. Dr. Kelley is now in his 55th consecutive year of medical practice, and is the oldest general practitioner of medicine in the metropolitan area of Indianapolis.

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NEWS NOTES

Continued

Lake Geneva, Wisc., Chosen For Children's Diabetic Camp

The thirteenth summer camp for diabetic children, sponsored by the Chicago Diabetes Association, will take place at Holiday Home, Lake Geneva, Wisc., July 16-Aug. 6. Boys and girls from eight through 14 years of age are eligible.

The camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician, in addition to the regular staff.

Rates are arranged in accordance with individual circumstances; applications may be obtained from the Association, 620 N. Michigan Ave., Chicago 11.

IAGP Road Show Held at Evansville

Speakers on the program for the Feb. 9 Road Show of the Indiana Academy of General Practice at Evansville included Irwin Herskowitz, Ph.D., Associate Professor of Biology, St. Louis University, and Alvin S. Sevine, Ph.D., Associate Professor of Microbiology, I. U. School of Medicine.

Dr. Alfred J. Niedermayer, Evansville, was chairman of local arrangements.

Ob-Gyn Board Exam Scheduled for April

The American Board of Obstetrics and Gynecology announces that the next scheduled examinations, Part II oral and clinical, for all candidates, will be held in Chicago, April 8-15.

Deadline for receipt of new and reopened applications for the 1962 examinations is Aug. 1, 1961.

Purdue Receives Grant To Complete Building, Facilities

Public Health Service recently announced a grant of \$65,270 to Purdue University for completion of Life Sciences Research Building and equipment. This is a part of the Health Research Facilities grant which in five years has awarded 756 grants totaling over \$149 million for expansion of medical research facilities.

Film Illustrates Drug Research

American Cyanamid Company has prepared a 10-minute 16mm sound film in color to illustrate modern drug research by pharmaceutical manufacturers. It is offered for free loan to adult groups. Requests should be sent to Modern Talking Picture Service, 3 E. 54th St., New York 22.

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50 mg. • L-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as CaHPO₄) 35 mg. • Phosphorus (as CaHPO₄) 27 mg. • Fluorine (as CaF₂) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K₂SO₄) 5 mg. • Manganese (as MnO₂) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as Na₂B₄O₇·10H₂O) 0.1 mg. Bottles of 100, 1000.

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FUTURE MEETINGS, SEMINARS, COURSES

South Bend Institute To Cover Maternal, Infant Care

Persons interested in improvement of maternal and infant care are invited to attend a maternity institute Apr. 6-7 at the Indiana Club, South Bend, Ind.

The institute is designed to be of benefit to obstetricians, pediatricians, G.P.'s, anesthesiologists, pathologists, office nurses, public health nurses, family agencies, institutional nurses, instructors and students.

Outstanding leaders in the fields of infant and maternal health will be on the program, which includes group discussions, round tables, lectures and tours.

Bunts Institute Offers Urology Course

A postgraduate course entitled "Current Urologic Problems" will be presented Mar. 23 and 24 by the Frank E. Bunts Educational Institute in Cleveland, Ohio. Sessions will be conducted by members of the Cleveland Clinic Foundation and guest speakers.

Due to auditorium capacity, registration will be limited to 125, with acceptances made in order of application.

Application blanks may be obtained from the Education Secretary of the Institute, 2020 E. 93rd St., Cleveland, Ohio.

Operative Clinics Included On April Surgeons' Program

The Indiana Chapter of the American College of Surgeons will hold its annual meeting in Indianapolis Apr. 14-15. Operative clinics will be held the morning of the 14th at several Indianapolis hospitals. An interesting and varied didactic program will be conducted the afternoon of the 14th and the morning of the 15th at the Rice Auditorium of the State Board of Health Building. Members of ISMA are invited to attend.

HOSPITAL HOUSEKEEPING COURSE OFFERED AT MICHIGAN STATE

A hospital housekeeping course will be repeated this year at Michigan State University from Apr. 3 to May 25. Enrollment is limited to 40 persons. The course, now in its 13th year, is sponsored by the American Hospital Association. Ten scholarships at \$350 each will be given by Huntington Laboratories of Huntington, Ind.

Courses to Cover EENT Subjects

The Gill Memorial Eye, Ear and Throat Hospital will conduct its 34th annual postgraduate courses in Roanoke, Virginia, Apr. 3 to 8. Otolaryngology will be covered Apr. 3, 4 and 5; ophthalmology, Apr. 5, 6, 7 and 8. A copy of the program and details of the course may be obtained by addressing Dr. E. G. Gill, Box 1789, Roanoke, Va.

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Deaths

Richard H. Callahan, M.D.

A former Lake County coroner, Dr. Richard H. Callahan, died suddenly Dec. 23 at his Indiana Harbor home. He was 48.

Dr. Callahan, a general practitioner, was a graduate of Rush Medical College, class of 1938.

Clifford E. Canaday, M.D.

Dr. C. E. Canaday, who practiced medicine 55 years before retiring in 1958, passed away Dec. 26 at the age of 84.

Dr. Canaday was New Castle city health officer for 35 years prior to his retirement.

He was honored by the ISMA 50-Year Club in 1950, having graduated from Pulte Medical College, Cincinnati, in 1900.

Ralph R. Coble, M.D.

One of Indianapolis' oldest practicing physicians, Dr. Ralph R. Coble, passed away Dec. 22 at the age of 81.

A general practitioner, Dr. Coble had a long career in public medicine. He was deputy Marion County coroner in the 1920's, superintendent of the former Indianapolis Dispensary, 1924-28; physician at the Marion County Infirmary at one time and medical inspector for the Indianapolis public schools for 20 years. A 1905 graduate of the Indiana Medical College, Dr. Coble did postgraduate work at Harvard and in London.

County Society News

Adams

Newly-elected members of the Adams County Medical Society include Drs. Richard K. Parrish, president; Norman E. Beaver, vice president; and Norval S. Rich, secretary-treasurer. The group met Jan. 10 at the Decatur Community Club.

Bartholomew-Brown

Twenty-three members of the Bartholomew-Brown Medical Society met Jan 11 to complete elections and install committees. Officers for the coming year are Drs. Robert Reid, president; Kenneth Schneider, vice president; and Forest Daugherty, secretary-treasurer.

Elected as delegates to state convention were Drs. David Adler and Robert Seibel. Their

Claude Dollens, M.D.

ISMA's 1958 Doctor of the Year, Dr. Claude Dollens, passed away Jan. 22 at his Oolitic, Ind., home. He had retired from practice two years ago.

Dr. Dollens was a teacher for five years before attending the Central College of Physicians and Surgeons, where he received his degree in 1907.

Dr. Dollens was a past president of the Lawrence County Medical Society and the Lawrence County Tuberculosis and Health Association. He was a former county health officer.

Virgil Jaye Fruth

A former Connersville physician, Dr. Virgil J. Fruth, 71, passed away Dec. 26 at his Florida home.

Dr. Fruth was a graduate of Chicago College of Medicine, class of 1912.

Martin T. Patton, M.D.

Dr. Martin T. Patton, 70-year-old Indianapolis general practitioner, passed away Dec. 10.

Dr. Patton was graduated from the Indiana University School of Medicine in 1917.

Scudder G. Welty, M.D.

Dr. Scudder G. Welty, 65, Fort Wayne physician for 37 years, passed away Jan. 17.

A general practitioner, Dr. Welty was a graduate of the Eclectic Medical College, Cincinnati, Ohio, class of 1923.

alternates are Drs. Slater Knotts and Henry McCullough.

Clark

Dr. Norman E. Forsee is the new president of the Clark County Medical Society. Other officers are Drs. Edsel Reed, vice president, and John S. Huoni, secretary-treasurer. Delegate to ISMA convention is Dr. George M. Wolverton; his alternate is Dr. Joel T. Carney.

Decatur

Members of the Decatur County Medical Society have elected Dr. Robert P. Acher president and delegate to ISMA convention. Other new officers are Drs. C. W. Callaghan, vice president and alternate delegate; Louis A. Walk-

COUNTY NEWS

Continued

er, secretary-treasurer; and William Shaffer, alternate delegate.

Dubois

Dr. John Beaven is the new president of the Dubois County Medical Society. Assisting him during the coming year will be Drs. Thomas H. Gootee, vice president, and Francis H. Gootee, secretary-treasurer. Dr. Charles Klammer is delegate to ISMA convention, and Dr. John Barrow will serve as his alternate.

Gibson

Dr. Melvin Fau, Evansville, spoke on "Arteriosclerotic Heart Disease" at the Jan. 11 meeting of the Gibson County Medical Society. Ten members attended.

E. V. Morchand, the society's new president, will be assisted by Drs. Harold Petitjean, vice president; W. R. Wells, secretary-treasurer; Virgil McCarthy, delegate; and R. E. Weitzel, alternate.

Harrison-Crawford

Newly-elected officers of the Harrison-Crawford Medical Society are Drs. Louis Blessinger, president; David Dukes, vice president; Richard Jordan, secretary-treasurer; William Amy, delegate; and Richard Jordan, alternate.

Henry

Dr. Robert Rohn spoke on "Common Bleeding Problems" at the Jan. 19 meeting of the Henry County Medical Society. The 28 attending included 12 local dentists who were invited to the meeting.

Howard

Thirty-seven members of the Howard County Medical Society met at Kokomo Jan. 3 for a general business meeting.

La Porte

ISMA President Dr. Guy Owsley spoke to 48 members of the La Porte County Medical Society at a Jan. 17 meeting.

Assisting Dr. Fred S. Carter, newly-elected society president, are Drs. John B. Cleveland, vice president, and George P. Backer, secretary. Delegates are Drs. G. O. Larson and T. D. Arm-

strong, their alternates being Drs. F. M. Fargher and J. C. Richter.

Huntington

Newly elected officers of the Huntington County Medical Society are Drs. Richard Wagner, president and delegate; Carl S. Ray, vice president and alternate, and Stanley M. Casey, secretary-treasurer.

Marshall

Dr. James O. Coursey, Jr., is the new president of the Marshall County Medical Society. Assisting him are Drs. James Hampton, vice president; and Lloyd France, secretary-treasurer.

Owen-Monroe

Twenty-three members of the Owen-Monroe County Medical Society heard a representative of the local RCA discuss the company's insurance program at a Jan. 26 meeting at Bloomington.

The society's newly-elected officers are Drs. Ambrose C. Estes, president; James B. Ross, vice president; James N. Topolpus, treasurer; John M. Miller, secretary; Dillon Geiger and Donald Blackwell, delegates; and William Link and M. S. Brown, alternates.

Putnam

Dr. B. T. Maxam spoke on "Upper Gastrointestinal Bleeding" at the Jan. 13 meeting of the Putnam County Medical Society. Sixteen members attended.

Wayne-Union

A Dayton, Ohio physician, Dr. Harry Nie-man, spoke on "Skin Cancer, Dermatitis and Syphilis" at the Jan. 10 meeting of the Wayne-Union Medical Society. Forty-two members attended.

Whitley

Dr. Warren Niccum is the new president of the Whitley County Medical Society. Other new officers include Drs. James Luckey, vice president; Park Huffman, secretary-treasurer; Thomas Hamilton, delegate, and Jules Heriter, alternate. ◀

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

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Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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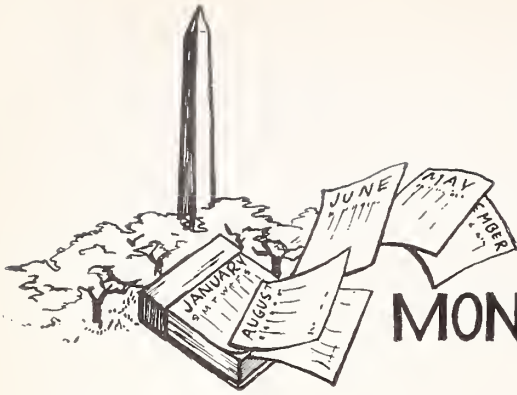
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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—The medical profession, the U. S. Public Health Service and the National Foundation are working together in an all-out drive to get as many persons as possible to take Salk vaccine shots before the summer polio season starts.

The Sabin live polio vaccine will not be available in quantity this year.

The Salk vaccine campaign drive is directed particularly at children and younger adults in the lower economic groups.

Dr. Julian P. Price, Florence, S. C., chairman of the American Medical Association's Board of Trustees, pointed out that many children and younger adults in the lower income groups have not been inoculated against polio.

"As long as 'islands of unvaccinated persons' exist even within well-vaccinated communities, polio epidemics remain a serious threat," Dr. Price said.

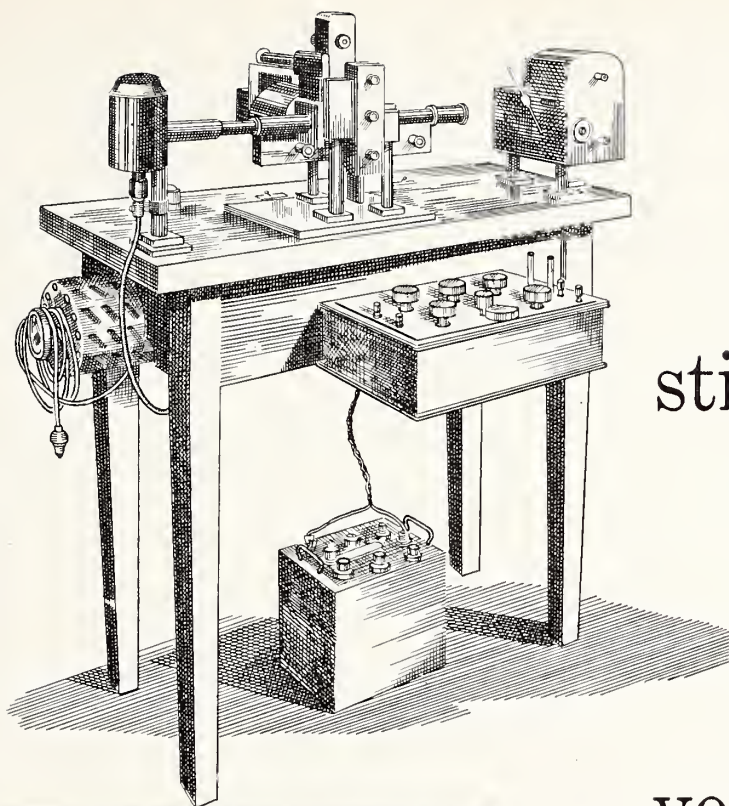
Dr. Luther L. Terry, Surgeon General of the Public Health Service, emphasized the need for immunizing infants. He also said that the PHS will encourage behavioral studies to determine reasons why some people refuse to take polio shots. It is hoped that then methods may be devised to overcome such refusal.

Dr. Terry called particular attention to the findings of the PHS's Advisory Committee on Poliomyelitis Control that the recommended dosage schedules may be modified to permit the administration of three shots of Salk vaccine before summer to persons who have not had any vaccine before.

Dr. Price stressed that success of the "babies and breadwinners" polio vaccine campaign depends on joint activity at the local level by medical societies, boards of health and voluntary health agencies. He expressed confidence that the more than 2,000 state and county medical societies throughout the country would cooperate wholeheartedly.

"Contrary to recent reports (in Scripps-Howard newspapers)," Dr. Price said, "the A.M.A. is strongly behind every effort to encourage the public to take advantage of the Salk vaccine without delay."

The Advisory Committee urged that "immediate steps . . . be taken by all interested groups to intensify drives for vaccination with the



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MONTH IN WASHINGTON

Continued

formalin-inactivated (Salk) vaccine." The Committee also endorsed the plan to direct the campaign particularly at the lower socioeconomic and younger age groups.

RECOMMENDATIONS FOR LIVE VACCINE

The Committee recommended that the first available supplies of the Sabin live, oral vaccine be utilized in the following priority order:

1. Epidemic control, investigations and community studies.
2. Immunization of infants and pre-school children.
3. Selected area immunization of those segments of the population that are least well immunized.

Congress now has before it legislation to carry out all of President Kennedy's broad health program, but it is doubtful that the lawmakers will act upon some of it this year.

Kennedy health legislation sent to Congress recently included bills on medical education and federal grants for nursing homes and other community facilities.

The Chief Executive also recommended an expanded program to combat water pollution. He requested Congress to authorize federal grants of \$125 million a year for 10 years to help states forming interstate water pollution control agencies. He also recommended increased federal aid to communities building sewage treatment plants.

The President proposed creation of a special unit in the Public Health Service to handle both air and water pollution matters.

DEEMS EDUCATION PROPOSALS KEYSTONE OF HEALTH PROGRAM

In accompanying letters to the presiding officers of the House and the Senate, Kennedy said he regarded his medical education proposals as the keystone of the overall health program because "we are not presently training enough (physicians) to keep up with our growing population."

The other bill would "make possible a substantial addition to the number of nursing home facilities to care for long-term patients, and . . . help relieve the shortages of home health care programs," Kennedy said.

The medical education measure would authorize federal grants for scholarships for medical and dental students. Each medical and dental school would be eligible for a total of scholarship grants equal to \$1500 times one-fourth of the enrollment after the program had been in effect for four years. The maximum individual scholarship would be \$2,000 a year. Participating schools also would be eligible for federal grants of \$1,000 per scholarship to help pay a school's operating expenses.

The community health facilities bill would increase the annual authorization for federal grants for construction of nonprofit nursing homes from \$10 million to \$20 million and raise the minimum state allotment from \$50,000 to \$100,000 per year. It also would broaden the PHS

Continued on page 450

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Literature available to physicians on request.

REFERENCES: 1. Carpenter, E. B.: Southern M.J. 51:627, 1958. 2. Forsyth, H. F., J.A.M.A. 167:163, 1958. 3. Hudgins, A. P.: Clin. Med. 6:2321, 1959. 4. Grisolia, A., and Thomson, J. E. M.: Clin. Orthopaedics 13:299, 1959. 5. Lewis, W. B.: California Med. 90:26, 1959. 6. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 7. Park, H. W.: J.A.M.A. 167:168, 1958. 8. Plumb, C. S.: Journal-Lancet 78:531, 1958. 9. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 10. Schaubel, H. J.: Orthopaedics 1:274, 1959.

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MONTH IN WASHINGTON

Continued from page 446

Surgeon General's authority to conduct research, experiments and demonstrations on development and utilization of hospital services, facilities and resources to include other medical facilities.

Federal grants also would be authorized to help finance studies, experiments and demonstrations by states and other nonfederal agencies for development of new or improved methods of providing health services outside hospitals, particularly for chronically ill or aged persons.

AMA FINDS 'MUCH TO APPLAUD' IN OVERALL PROGRAM

The AMA found "much to applaud" in Kennedy's overall health program, but stood fast in opposing the proposal to provide elderly persons with health care through the social security system. Dr. F. J. L. Blasingame, executive vice president of the AMA, said:

"We support the broad principles and the general goals of the President's program, but we cannot support his proposal for hospitalization and nursing home care for persons over 65 under social security.

"In fact, after studying this section of the President's plan, the AMA more strongly than ever reaffirms its support of the Kerr-Mills law."

Groundbreaking Planned



DR. GUY OWSLEY (seated left), ISMA president, and Dr. Irvin Wilkens (standing right), ISMA treasurer, present the ISMA check for purchase of property at 3935 N. Meridian St., Indianapolis, site of new ISMA headquarters, to Mr. Samuel J. Mantel (center). W. A. Brennen, Jr. (standing left), handled the transaction. Seated at right is Ralph Hamill, ISMA legal counsel.

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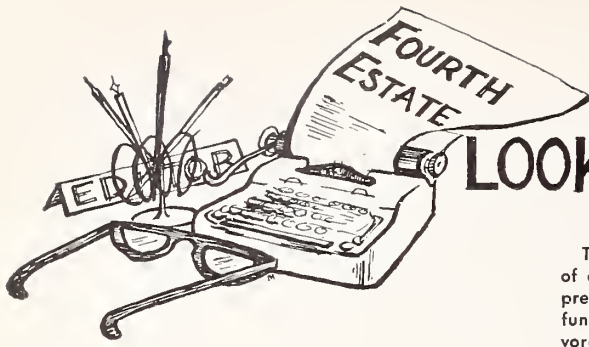
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Everyman's Problem

A Doctor Analyzes Socialized Medicine

By Harry T. Everingham

Mrs. E. L. E. writes: "Is it possible that we are going into socialized medicine with our eyes closed? What do doctors think of it?"

Dear Mrs. E.: One doctor, Ruth M. Bain, M.D., Austin, Tex., thought the subject of sufficient importance to write a letter to all her patients, and the Association of American Physicians and Surgeons thought enough of that letter to run it as a bulletin. Here's what Dr. Bain wrote:

"It is now 4 a.m. I have just talked by phone with a patient and, I believe, relieved her anxiety. She will no doubt be back asleep before I am. I wonder how well this will work some 10 years, or perhaps less, from now when the government will probably be between me and my patient.

"Ridiculous? No! A very likely possibility in my opinion. Not because the American people want it, but because of lack of information and concern about what is happening to us—lethargy on the part of the public. I am greatly disturbed by the fact that every candidate aspiring to the presidency this year has come out for some form of government paid-for (socialized) medicine—admittedly on a limited basis at this time—but how long will it stay limited? If precedence set in other legislation is followed, the scope of the program will be broadened each election year.

"This year it is all for 'the aged.' Nobody knows what the needs of the aged are, but it has tremendous emotional appeal. Everybody—if they live long enough—will very probably have some health problem. Is this their greatest problem? Many of those I see have health problems produced primarily by loneliness and lack of a

feeling of being needed. Some have nutritional problems—not because of lack of food—but lack of someone to eat with, or prepare it. Will government medicine change this?

"The medical profession has been and is being accused of selfish interests in their efforts to defeat or delay socialized medicine. This is without basis in fact. Do you know of any other profession whose every effort is toward elimination of need for their services? The medical profession is made up of rugged individualists—this is the type of person who makes a good doctor. It takes a fair amount of ruggedness (guts, if you wish) to carry the responsibility and make the decisions necessary to practice medicine. This type of individual does not tolerate regimentation.

"I am convinced that when socialized medicine has been accomplished that the type of individual who chooses to go into medicine will change—and not for the best. Regimentation has a leveling effect—it breeds mediocrity. This will eliminate the type of progress that has added 20 years to our average life expectancy in the last 50 years.

"Is it selfishness that prompts me to fight these developments that, not only are distasteful to the point of nausea to me, but that I feel will be bad for everybody concerned—especially the future generations who will be paying the bills? Did you know that social security taxes by 1970 are already scheduled to reach the rate of nine percent without any broadening of the program? And are you aware that in Sweden, 25 percent

Continued on page 458



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PRECAUTIONS: As with many other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs discontinue medication. Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York 

FOURTH ESTATE

Continued from page 454

(one-fourth) of all paychecks is withheld for social security, including the socialized medicine program of the country? Do you spend one week's salary a month paying medical bills?

"It is my very earnest desire to stimulate you to find out more about bills before your Congress and to make your wishes known to your elected representatives. If you want socialized medicine, fine—I hope you will be happy! But if you do not, you must actively work to avoid it. It is very nearly a reality."—Sincerely, Ruth M. Bain, M.D.

Indianapolis Star
Jan. 23, 1961

The 'Logic of Subsidy'

Perhaps the least surprising event of the week was the hearty endorsement of President-elect Kennedy's "task force" for the idea of providing medical care for the aged under Social Security.

It is argued, and not by Democrats only, that this approach is just a "logical" extension of the Social Security program. This view was set forth by Republican Marion B. Folsom, former Secretary of Health, Education, and Welfare, at the current White House Conference on the Aging. The cost of a medical subsidy for the aged, said Mr. Folsom, could be met by "a small tax" on wage-earners and employers without "adverse effect" on the Federal budget or the economy.

That is also the rosy prospect unfolded by Mr. Kennedy's advisers, and it could conceivably occur. But the logic of the welfare subsidy idea is against it.

We have come so far since the birth of Social Security, and become so accustomed to its gradual extension (especially during election years), that we sometimes forget the program was originally quite limited. Now, it is urged that government assume responsibility for the health of an entire class of citizens, regardless of individual need.

If the implications of this step are not readily apparent, it is mainly because each extension of Social Security benefits has set a gloss of "reasonableness" upon the next. If it is thought fair and reasonable that every citizen should be compelled to pay for "benefits" he neither wants nor needs, in order to meet the presumed needs of a relatively few, these are the standards a pa-

ternal government has taught us. Where does the welfarist's train of thought lead?

It must come, plainly, to more and more dependence upon government. For if one class of citizens is endowed with a "right" to free medical care because of age alone, how, logically, can others be denied a like "right" based on income, occupation or any other criteria mustering sufficient political strength? In fact, Mr. Kennedy's task force proposes to make the children of unemployed parents (themselves receiving benefits) the government's dependents and perhaps the forerunner of Federal medical care for the young. Why not? Politicians have yielded to pressures for more dubious extensions of welfare subsidies in the past, and must be expected to do so again.

Nor is it reasonable to assume that "a small tax," as foreseen by Mr. Folsom and estimated at an additional one-half of one percentage point by the task force, would cover the cost of so broad and unpredictable a program as medical care for the aged—especially when the "logic" of expansion is built into the subsidy. The British, pleased with the first modest price-tag on their "free" health service, later learned that estimates are only guesses which can go wildly astray.

The fact is, at any given moment, the welfare subsidy arrangement is likely to be unfair and illogical, never mind how unsound economically. So, each step on the welfare road can be considered "logical" only if we are prepared to go the whole journey.

Wall Street Journal
Jan. 12, 1961

Needless Tragedies

The terror of polio is largely licked. The vaccines work. National epidemics have been cut to almost nothing.

But in the Southeast Side of Indianapolis, four children in one family were stricken with this disease last month. Two died.

More than half the county's polio cases in the past year occurred in that neighborhood.

And of the people living there, 64% have not received shots. Even among the children, 44% have not received shots.

No wonder polio still haunts the neighborhood. Salk shots ARE available.

From a doctor, from a clinic—free for those who can't afford to pay.

Continued

Annual Cancer Issue

Uterine Exfoliative Cytology in a Private Medical Laboratory

JOSEPH L. HAYMOND, M.D.

Indianapolis

EXFOLIATIVE CYTOLOGY has been utilized most successfully in many areas during the past 18 years in the study of vaginal and cervical secretions for the diagnosis of early carcinoma of the cervix of the uterus.¹ The method makes possible an early diagnosis on asymptomatic patients of an accessible lesion and makes it possible for the physician to initiate the most effective form of treatment.

For the past 10 years we have provided service through our private medical laboratory to physicians in the Indianapolis area for the utilization of the cytologic method in their office practice. The number of vaginal and cervical smears submitted to us during this period has shown a gradual increase and provides some index of the interest of physicians in this procedure.

An analysis of the results obtained in the study of 17,958 patients during the past two years showed 154 cases in which the cytologic findings were an indication for additional studies. Our methods and the interpretations which may be made from cytologic reports will be discussed.

Methods

To facilitate use of the cytologic method of vaginal and cervical smears in the physician's office, all items which are used in the prepara-

tion of smears for a single patient are assembled in suitable package form and made available to the physician. They include:

- 1 requisition form with instructions on the reverse side.
- 2 non-absorbent cotton swabs for vaginal (V) and cervical canal (Cc) smears.
- 1 Ayre scraper for cervical scrapings (Cs).
- 3 frosted end microslides labeled V, Cs, and Cc with steel paper clips attached to the slides.
- 1 two-ounce wide-mouth bottle containing 95% alcohol fixative.

Smears of the secretions are requested from three separate areas as recommended by Papanicolaou.²

1. From the vaginal pool (V).
2. From the cervical canal (Cc).
3. From the squamo-columnar junctional area at the external os of the cervix (Cs).

The smears are usually received from the physician's office in the bottle of fixative or the slides may have been removed from the fixative and packed in mailing containers according to the convenience of the physician's office.

Each set of smears is processed and stained by the Papanicolaou method which we have found to be the most satisfactory for this pur-

pose. Each of the three separate smears from the vaginal pool, the cervical scraping and the cervical canal is screened by a cytologic technician using the low-power magnification to observe all unusual or questionable cell groups which are marked by an ink dot for the subsequent review of the pathologist.

Smears which show no abnormal cells are classified as negative by the cytologic technician. Those which show abnormal cells or cell groups are reviewed by the pathologist and the classification and interpretation is made by him.

The report form which is modified from the forms utilized in the cytology laboratory of James W. Reagan, M.D., Western Reserve University,³ conveys the following information:

- ☐ Cell study negative. Repeat in one year.
 - ☐ Cell study unsatisfactory because of _____.
 - ☐ Repeat cellular studies in this case in _____ months.
 - ☐ Cellular study indicates need for further diagnostic study.
- It is generally accepted that studies include
- ☐ Punch Biopsies
 - ☐ Conization
 - ☐ Curettage

Cellular Changes:

The terms used in the description of cellular changes in vaginal and cervical smears are as follows:

NEGATIVE indicates the absence of abnormal or suspicious cells.

SUSPICIOUS indicates cells with abnormal features which are not conclusive for malignancy.

POSITIVE indicates cells and cell clusters considered conclusive for malignancy.

ATYPIA indicates the presence of atypical cells which deviate from the normal cells but do not present definite suspicious features.

DYSPLASIA indicates the presence of immature or abnormal cells of dysplastic type.

Important Points in the Technique of Smear Preparation

1. The patient should *not* have taken a douche on the day of examination as the vaginal secretions will be greatly altered. Since the vaginal smear (V) is a valuable supplement in the diagnosis of adenocarcinoma of the body of the uterus, it should always be included. A douche

does not interfere with collection of cervical scraping (Cs) smear or cervical canal smear (Cc) but may render these smears less satisfactory for interpretation.

2. Avoid the use of lubricant jelly in inserting the speculum as this material interferes with the staining of the smears. If the speculum is moistened with water this will suffice for the lubrication in most instances.

3. With the patient in the lithotomy position and the vaginal speculum in place so that the cervix may be clearly visualized, dip a non-absorbent cotton swab in the secretions of the vaginal pool at the fornix. Stroke the swab gently over the surface of the microscope slide labeled "V" leaving a layer of secretions with both thick and thin areas. Before drying occurs, immerse slide promptly in the fixative. The paper clip over the end of the slide will prevent the adherence of the subsequent slides.

4. If information on the hormonal status of the patient is desired, obtain additional secretions from the lateral vaginal wall near the fornix on a separate slide.

5. Insert a non-absorbent cotton swab into the cervical canal and twirl gently so as to obtain endocervical mucus and secretions. Then roll the swab over the surface of the slide labeled "Cc" in the reverse direction so as to "unwind" the roll of mucus obtained without smearing, as smearing will distort the cells and interfere with interpretation. Plunge the slide *promptly* into the fixative.

7. Allow the smears to fix for at least 15 minutes and preferably for one hour or longer. The smears may be sent to the laboratory in the bottle of fixative or they may be removed from the fixative and allowed to dry. The dried slides may be packed in a mailing container with paper wads and mailed to the laboratory. In either event the preparations are well preserved for a number of days so that a delay in arrival at the laboratory does not affect the satisfactory handling of the specimen.

Recommendations Evolving from Cytologic Studies

1. *Negative reports:* In the absence of clinical findings, a negative result may be accepted as excluding of the presence of carcinoma of the cervix in over 90% of the cases.¹ However, this presumes that the smears for cytologic study must have been entirely satisfactory for interpre-

tation and include smears from each of three areas; namely, the vaginal pool smear (V), the cervical canal smear (Cc) and the cervical scraping smear (Cs).

A negative smear finding in the face of clinical symptoms is not valid. This applies particularly to the diagnosis of abnormal bleeding in the post-menopausal years where a study of the patient by dilatation and curettage is mandatory in order to exclude the possibility of carcinoma of the body of the uterus.

While the preparation of the vaginal and cervical smears should not be a difficult procedure for physicians, the cytology laboratory must clearly indicate to the clinician those smears which are unsatisfactory for study and request repeat smears. Even under ideal conditions, not all of the smears prepared will be satisfactory. We consider the cervical scraping smear to be of greatest importance in the screening for carcinoma of the cervix; however, the cervical canal and the vaginal pool smears are valuable adjuncts which should not be omitted.

2. *Positive* cytologic smears should always be confirmed by biopsy studies before treatment is instituted, as the type of treatment is more suitably indicated by biopsy findings. Invasive carcinoma is usually treated by radiation therapy, whereas the presence of carcinoma in situ may be taken as an indication for hysterectomy.⁴

3. *Suspicious* findings should be interpreted as indicating the presence of cells which may or may not be from carcinoma, and suspicious findings are frequently associated with the presence of either atypical cells or dysplastic cells in variable numbers. In the absence of clinical symptoms or visible lesions of the cervix, repeated smear studies at monthly, bi-monthly or tri-monthly intervals may resolve the problem in that the abnormal cells may disappear. If the abnormal cells persist or if there are clinical symptoms, biopsy is indicated even in the absence of clinical findings.

4. *Dysplasia* may co-exist with carcinoma in situ.⁵ On the other hand, dysplasia is a fairly common finding which may be associated with pregnancy and may disappear on subsequent study. The finding of dysplasia is a definite indication for careful follow-up observation of the patient, and the severity of the dysplastic change may be used as a guide to the follow-up procedure. Ordinarily we recommend follow-up

smears at intervals of three months. In cases of mild dysplasia (those in which only a few dysplastic cells are recognized in the cytologic preparations) follow-up studies at yearly intervals may be sufficient in the absence of symptoms.

5. *Atypical* cells (Atypia) are most frequently associated with inflammatory conditions of the cervix, and are not of neoplastic type. Follow-up smear studies usually resolve the question; but biopsy is indicated if suspicious symptoms or physical findings are present.

6. *Biopsy procedure.* Surgical "Cold" conization of the cervix should be performed *without* prior instrumentation, for the procurement of a biopsy specimen to evaluate the positive or suspicious findings on cytologic study; otherwise, a small lesion in the cervical canal may be missed.⁴ If curettage is to be performed, the dilatation of the cervix should follow the cervical biopsy.

The use of the electrocautery in the procurement of a biopsy specimen will produce cellular changes in the tissue which render the interpretation difficult or impossible and therefore all biopsy material should be taken with a scalpel or other suitable instrument.

Use of the Cytologic Method in the Diagnosis of Endometrial Carcinoma

We recommend that the vaginal pool smear be obtained routinely as a part of the cytologic study, as this smear has been found the most useful in detecting early carcinoma of the body of the uterus.⁶ In addition to the finding of recognizable carcinoma cells, certain other criteria are reported to the clinician as suspicious for adenocarcinoma:

1. Finding of endometrial cells after the 10th day of the menstrual period and before the next cycle or at any time in the menopause is abnormal.

2. Findings of numerous small histiocytes in the post-menopause is significant.

3. The finding of evidence of a high estrogen activity in the post-menopause which is not explained by the administration of hormones or by the presence of inflammation such as trichomoniasis.

Results

Table I indicates the total number of cytologic studies referred to us during the 10-year period from 1950 to 1960 and demonstrates the gradual

Total Cytologic Studies — 1950-1960

1950	76
1951	99
1952	170
1953	315
1954	551
1955	988
1956	2512
1957	4226
1958	5551
1959	8606
1960	10133

TABLE I

increase in the number of examinations requested. The greater proportion of the cytologic studies (98% in 1960) were for the vaginal and cervical smears.

In 1960, 213 physicians requested 10,133 examinations; 4,835 of the 10,133 examinations were requested by 11 gynecologists in Indianapolis who used the vaginal and cervical smear as a routine procedure in their offices; 4,835 additional examinations were requested by 162 physicians in Indianapolis, and 463 examinations were requested by 40 physicians outside of Indianapolis.

Table II shows the total number of cytologic studies requested from four separate community hospitals in four counties adjacent to the Indianapolis area where the writer has served as pathologist during the past 10 years. At the present time cytologic studies of the vaginal and cervical secretions are not utilized as a routine

procedure by physicians in these areas. In 1960, 738 cytologic examinations were requested by physicians in these four counties.

Table III presents an analysis of the results obtained in the study of 17,958 patients during the past two years (1959 and 1960); 154 patients showed cytologic findings which indicated a need for further diagnostic studies.

Information concerning the follow-up studies on the 154 cases was obtained from the physicians by questionnaire. Diagnosis of carcinoma was confirmed by biopsy in 61 cases, of which 36 cases were carcinoma in situ of the cervix, 20 cases were invasive squamous cell carcinoma of the cervix and five cases were adenocarcinoma of the body of the uterus.

Thirty-one cases were classified as positive by the cellular studies. Twenty-nine biopsy studies revealed 26 carcinomas of which 13 were of carcinoma in situ.

Fifty-three cases classified by cellular studies as suspicious had 45 biopsies which verified the presence of 24 carcinomas, 15 of which were carcinoma in situ.

Forty cases classified by cellular studies as dysplasia had 15 biopsies with findings of carcinoma in nine cases, seven of which were of the carcinoma in situ.

Thirty cases showed presence of atypical cells in which follow-up studies were requested at the time of the cytologic examination. There were 11 biopsies in the 30 cases, one of which

Cytologic Examinations Referred from Community Hospital Laboratories in Indiana — 1950-1960

	New Castle (35 Doctors)	Greenfield (25 Doctors)	Rushville (12 Doctors)	Noblesville (25 Doctors)
1950	0	0	0	0
1951	0	0	0	0
1952	20	0	15	2
1953	3	6	10	0
1954	4	28	66	0
1955	5	37	36	0
1956	26	60	49	1
1957	110	120	73	0
1958	133	199	66	17
1959	197*	244	99	88
1960	275*	280	113	70

* Examinations by Calvin Steussy, M.D., Pathologist, Henry County Hospital, New Castle.

TABLE II

Analysis of Results of Cytologic Studies of Uterine Secretions 1959-1960

CATEGORY	Number of Cases	Follow-up Biopsy Performed	Invasive Squamous Cell Carcinoma Confirmed by Biopsy	Carcinoma in Situ Confirmed by Biopsy	Endometrial Carcinoma Confirmed by Biopsy	Biopsy Showed Benign Tissue	Follow-up Smear Negative	No Follow-up
Total Number of Patients.	17,958		20	36	7			
Total Number of Separate Cell Studies.	18,547		20	36	7			
Cell Study Negative. Repeat in 1 year.	18,391				2			
Cell Study Unsatisfactory. Repeat.	85							
Cellular Studies Indicate Need for Further Diagnostic Studies.	154	104	20	36	5			
Cellular Studies Classified as Positive. Biopsy Recommended.	31	29	12	13	1	3	0	0
Cellular Studies Classified as Suspicious. Biopsy Recommended.	53	45	5	15	4	21	5	3
Cellular Studies Classified as Dysplasia. Follow-up Studies Requested.	40	19	2	7	0	10	10	9
Cellular Studies Classified as Atypia. Follow-up Smears Requested.	30	11	1	1	0	9	4	15

TABLE III

Case Finding Rate in Our Cases Compared to Other Series

	Our Cases per 1,000 Women	Cases per 1,000 Women ⁸	Cases per 1,000 Women ¹⁰	Cases per 1,000 Women ⁹
Abnormal Smears	8.5		17.29	
Carcinoma in Situ of Cervix	2.0	2.45	3.12	3.6
Invasive Carcinoma of Cervix	1.1	1.50	4.08	3.1
Adenocarcinoma of the Body	0.28	0.21		
Number of Cases Studied	17,958	608,200	4,163	108,136

TABLE IV

revealed carcinoma in situ and one biopsy showed invasive carcinoma.

Five cases classified by the cellular studies as positive or suspicious were revealed to have an adenocarcinoma of the body of the uterus by the biopsy study.

Three cases of adenocarcinoma of the endometrium and one case of adenocarcinoma of the cervix were revealed by biopsy study on cases in which the cytologic smears had on one occasion been classified as negative for malignant cells.

Comments

The case finding rates in our series given in Table IV are comparable to those given by Kaiser⁸ of the National Institute of Health in a review of proven cancers among 600,000 women with a first examination, but are somewhat lower than case finding rates listed by others.⁹ As all of our cases were referred by private physicians, they represent persons with the higher socio-economic status in this area, and this factor has been demonstrated to be of importance in the prevalence of carcinoma, as emphasized by Christopherson.¹⁰ However, we hasten to point out that biopsy studies have not been made as yet in a considerable number of our cases, and additional cases of carcinoma may be recognized at a later date.

Summary

Ten years of experience in the operation of a cytologic service to physicians for the screening of vaginal and cervical smears for carcinoma of the cervix of the uterus confirms the experience of many others that this is a practical clinical method which is adaptable to routine use by physicians in their office practice.

Cytologic studies do not replace the biopsy of

visible lesions, but are a valuable supplementary or complementary procedure to biopsy study in those cases in which a biopsy is not done for one reason or another. It should be used in conjunction with biopsy in all cases where anything less than a complete cold conization of the cervix is performed.

Analysis of findings in 17,958 unselected cases submitted for routine screening from private physicians' offices showed 154 cases (0.85%) to present abnormal smear findings which served as an indication for further diagnostic studies by biopsy and follow-up cytologic studies. Biopsy has been performed in 104 cases and the diagnosis of carcinoma has been confirmed in 61 cases (0.34%) of which 36 cases (0.2%) were of the carcinoma in situ (intraepithelial) type. Physicians utilizing the cytologic procedure for routine screening in their office practice may anticipate encountering a similar number of cases.

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Coffee Breakfast and Coffee Breaks

There are those who like to start the day well fortified by a substantial amount of fuel derived from a good breakfast. There are others who gulp a cup of coffee and call it quits. The latter class has always seemed queer to one with a healthy appetite. Perhaps it counts on an early snack in the morning break which seems to be obligatory in most activities.

Studies of work capacity of people who have no breakfast but indulge in the midmorning break, providing miscellaneous food, indicate that the performance of these people is significantly less efficient than that of others who eat a conventional breakfast. Maybe this weakens the argument for the numerous breaks now considered essential by many workers. The time seems to be coming when the breaks will be for work rather than refreshment.

Please pass the ham and eggs.—*Journal S. Carolina Med. Assn.*, reprinted in the *West Virginia Med. Journal*, Jan., 1961.

A Case Report

Islet Cell Carcinoma of the Pancreas

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CARCINOMA ARISING from the islet cells of the pancreas is a relatively infrequent lesion. Thus Lopez-Kruger and Dockerty¹ in a review of 10,314 necropsies found five insulin-producing carcinomas. At the Los Angeles County Hospital over a 25-year period Rogers² found six carcinomas. In view of the relative infrequency of this lesion a case studied at the Indiana University Medical Center is being reported.

Case Report

A 43-year-old white housewife was first seen in the preliminary diagnostic clinic of the Robert Long Hospital Oct. 13, 1953 with the chief complaint of "cirrhosis." She dated the onset of her illness to 1949, with weakness, tiredness and right upper quadrant discomfort. She subsequently developed abdominal swelling without pretibial edema. After six months of these symptoms, she consulted her physician, who referred her to a diagnostic clinic with a clinical impression of cirrhosis.

At this clinic, a needle biopsy of the liver was performed and was reported as carcinoma. No definitive therapy was carried out at that hospital. At another institution, the patient received nonspecific therapy for cirrhosis. In addition, she was given a prolonged course of X irradiation over the area of her liver. Her complaints continued but she was not incapacitated until April of 1953 when marked abdominal

swelling and edema of the lower extremities reduced her capacity for normal activity.

Past history included the fact that she had a gynecologic operation of unspecified type early in 1949 because of metrorrhagia of some months' duration. She had three living children as well as four miscarriages, each miscarriage followed by a dilatation and curettage. Review of systems was otherwise negative. Specifically, she denied dizzy spells, fainting and convulsions. She used alcohol in moderation and had had a good dietary intake. She had been troubled by constipation recently.

Physical Examination

The patient was an emaciated (weight 128 pounds, 58 Kg) chronically ill, white woman appearing older than her stated age. She was alert, cooperative and intelligent. Her temperature, blood pressure, pulse rate and respirations were within normal limits. The skin and sclerae were slightly icteric. Examination of the distended abdomen revealed a fluid wave and shifting dullness. The liver was hard, nodular and greatly enlarged. The spleen was not palpated. Four plus pitting edema was present over the ankles and pretibial areas. No spider angiomas were found, but typical "liver palms" were present. The remainder of the physical examination was negative.

The patient was admitted to the hospital on Oct. 20, 1953. At that time she was extremely lethargic, dehydrated and critically ill. Physical signs were unchanged except for increased ascites and icterus.

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Laboratory Examinations

The hemoglobin level was 10 gms per 100 ml, the leukocyte count, 10,000 per cu mm, with two bands, 83 adult polymorphonuclear leukocytes, 11 lymphocytes, two monocytes and one basophil. The packed cell volume was 37%. A specimen of urine obtained by catheter contained 20 to 25 pus cells per high-power field.

The serum alkaline phosphatase level was 37.5 King and Armstrong units, the total serum protein level was 6 gms per 100 ml, with albumin 3.9 and globulin 2.1 gms per 100 ml. Serum bilirubin level at one minute was 0.9 mg per 100 ml, the indirect was 1.1 mg per 100 ml, total 2 mg per 100 ml. Bromsulfalein level was 30% retention in 45 minutes. Thymol turbidity was one unit.

The total serum cholesterol level was 220 mg per 100 ml, with 56% esters. The serum cephalin flocculation level was 3-plus.

The total non-protein nitrogen level was 97 mg per 100 ml, the fasting blood sugar was 78 mg per 100 ml, the serum potassium level was 6.7 mEq per liter. A serologic test for syphilis was negative. No malignant cells were seen by cytologic examination of a specimen of ascitic fluid. A roentgenogram of the chest revealed bilateral elevation of the diaphragm but was otherwise normal. Barium swallow revealed a normal esophagus.

Hospital Course

A paracentesis was done immediately after admission and approximately 9500 ml of yellow-green clear fluid was removed. Following this, palpation of the abdomen revealed a large hard nodular mass which appeared to fill the greater portion of the abdomen.

There was no change in the patient's condition immediately after paracentesis; however, within the next two days the ascites rapidly reformed and her general condition deteriorated. She died Oct. 23, 1953 (her tenth hospital day and four years after the onset of the illness).

Necropsy Findings

The examination was performed five hours postmortem. Gross examination revealed a deeply jaundiced, emaciated patient whose abdomen was distended tightly.

On opening the abdomen six liters of yellow serous fluid were removed from the peritoneal cavity. The previously noted mass was identified



FIGURE 1
PHOTOGRAPH OF THE ABDOMINAL ORGANS *in-situ* at the time of necropsy. The liver contains many nodules of metastatic neoplasm which cause it to extend into the pelvis. (Photograph through the courtesy of Dr. R. A. McDougal.)

as the liver, weighing 9400 gms. Most of the surface consisted of yellow nodules varying in size from less than 1 mm to 14 cm in diameter. On cut section, similar nodules were found to occupy almost the entire substance of the organ. Some of the larger nodules had necrotic centers and two of them were cystic and filled with bile-stained fluid. The gallbladder was buried by the over-growth of tumor, but on being dissected free, its walls appeared to be free of tumor. The hepatic ducts were patent, although tumor-bearing lymph nodes completely enveloped the hepatic, cystic and common bile ducts.

The weight of the pancreas was 100 gms. In the tail of the pancreas was a nodule, 3 cm in diameter, composed of radiating strands of light gray, dense connective tissue enclosing darker gray nodules. The remainder of the pancreas was sectioned at 0.5 cm intervals and no other abnormalities were observed. This nodule was regarded grossly as the primary site.

Other sites of metastases included the lymph nodes in both inguinal regions, around the iliac

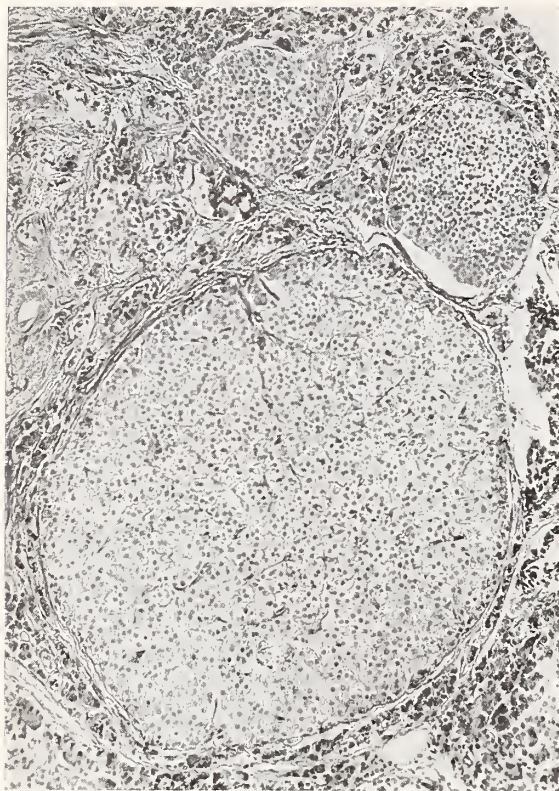


FIGURE 2

SECTION OF A NODULE of the tumor in the pancreas. The two nodules at the top represent "normal islets." The large nodule consists of tumor. The resemblance to normal islets and the organoid arrangement are characteristic of tumors of the islands of Langerhans.

arteries, aorta, pancreatic artery, hila of the liver and spleen, falciform and coronary ligaments of the liver, mediastinum, internal mammary artery and of the thoracic duct. Visceral metastases were noted in the liver and in the myocardium. Extensive metastases were present on both surfaces of the diaphragm and a single 2 mm implant was found on the visceral pleura of the right lung.

Other anatomic diagnoses included hemorrhoids and slight arteriolar nephrosclerosis.

On microscopic examination the tumor in the pancreas and in the metastases was composed of a dense connective tissue stroma containing islets of cells, some of which, when stained with hematoxylin and eosin stain, and Masson's trichrome stain, were indistinguishable from normal islet cells of the pancreas. Others were small and consisted of densely chromatic nuclei and homogeneous basophilic cytoplasm. After staining with Gomori's stain for beta granules, none of the cells of the tumor contained specific gran-

ules, although cells of normal islets in the section contained scattered blue granules.

A microscopic section from the needle biopsy in 1951, kindly furnished by Dr. M. D. Dockerty, included cells similar to those seen in the sections from the post-mortem material. Pertinent negative findings at necropsy were the surgical absence of the internal genitalia and appendix, absence of any tumor or ulceration of the bowel and normal appearance of the parathyroid and adrenal glands.

Previous Case Reports

The first well-recognized case of a tumor arising from the islands of Langerhans was described by Nicholls³ in 1902 as an adenoma discovered incidentally at necropsy. Following this, sporadic reports of this tumor occurred in the literature. It was not until the discovery of insulin in 1922 by Banting and Best, and the development of the concept of hyperinsulinism by Harris in 1924, that the possible clinical significance of some of these tumors was recognized.

Wilder⁴ in 1927 described the first islet cell tumor associated with clinical hyperinsulinism. This was also the first islet cell carcinoma to be described.

Subsequently, interest in these tumors developed and a number of case reports and reviews were published. Among these was that of Gordon and Olivetti.⁵ In 1950, Howard, Moss and Rhoads⁶ published an extensive review of the literature dealing with islet cell tumors. In this review they found a total of 37 islet cell carcinomas (including one of their own cases) of which 22 were functioning and 15 were non-functioning. Since then, a number of reports dealing with this tumor have appeared, two of the most recent being those of Rogers² and of Sieracki.⁷

At the time that Howard and co-workers published their review, islet cell tumors were felt to be either benign or malignant, with or without insulin production, or of doubtful malignancy with or without insulin production. Subsequently, islet cell tumors of the pancreas have been associated with a number of other conditions. Del Castillo et al.⁸ in 1950 reported a case of a 38-year-old woman who had a non-functioning carcinoma of the islets of Langerhans associated with Cushing's disease. At necropsy a basophilic

adenoma of the pituitary and hyperplasia of the cortices of the adrenal glands were found.

Rosenberg⁹ reported the case of a 40-year-old woman with Cushing's syndrome clinically, in whom an islet cell carcinoma of the pancreas, and hyperplasia of the cortices of the adrenal glands were found at necropsy. Balls and associates¹⁰ have published a third such case.

Even before 1950 some of the case reports (among them one of Gordon's⁵ cases) included the occurrence of peptic ulceration as an incidental finding in cases of islet cell tumor. It remained for Zollinger and Ellison¹¹ and for Ellison¹² to call attention to this syndrome of islet cell tumor, massive gastric hypersecretion and intractable peptic ulceration. This finding, too, has been substantiated by a number of authors including Donaldson et al.,¹³ Thistlethwaite and Horwitz¹⁴ and Maynard and Point.¹⁵ The most extensive review of these "ulcerogenic tumors" is that of Ellison. He lists a total of 24 islet cell tumors associated with peptic ulceration. Of these, 19 were classed as malignant tumors. Sieracki et al.⁷ in a review of 29 islet cell tumors reported nine instances of peptic ulceration. Of these tumors, four were benign and five malignant.

Severe intractable diarrhea complicated by hypokalemia was described by Verner and Morrison¹⁶ in a case of islet cell adenoma of the pancreas. A number of other case reports, including those of Donaldson,¹³ Thistlethwaite, (case no. 1)¹⁴ and Rosenberg,⁹ list diarrhea as one of the presenting symptoms. In Sieracki's cases four of the patients had complaints of diarrhea. Neither diarrhea nor peptic ulceration was found in our patient. Lastly, steatorrhea resembling non-tropical sprue has been reported in association with islet cell carcinoma of the pancreas.¹⁵

Islet cell carcinomas can arise in any part of the pancreas. Howard and co-workers⁶ reported that of 34 cases in which the site was listed, 12 were located in the tail of the pancreas, 11 involved the entire organ, seven involved the tail and body and four the head. The most frequent sites of metastasis are the regional lymph nodes and liver, although other possible sites include the thoracic and abdominal lymph nodes and lungs.

Within the liver these tumors often reach enormous size. In Gordon's⁵ second case the weight of the liver was 6550 gms. In our case

the weight of the liver was 9400 gms. Islet cell carcinoma may occur in either sex. In Howard's review⁶ of the 36 cases in which the sex was stated, 24 were male and 12 female. Ages of the patients ranged between 18 and 73 years with 29 of the 37 cases occurring between the ages of 30 and 60 years. The malignant nature of the tumors can be definitely established only on the basis of finding metastases. In a number of instances tumors demonstrating cellular atypia, nuclear hyperchromatism, increased numbers of mitoses and capsular invasion have subsequently behaved clinically as benign lesions. Sieracki et al.⁷ were unable to find any significant difference in the incidence of nuclear pleomorphism and nucleolar prominence between the benign and malignant tumors. Complete encapsulation of benign lesions was a rare finding. It is of interest to note that blood vessel invasion was noted in three of their benign lesions and in five of seven carcinomas.

Duration Varies

The rate of growth of islet cell carcinomas is quite variable. Of the cases reviewed by Howard and associates⁶ the duration of illness varied between 3½ weeks in a functioning carcinoma and 16 years also in a functioning tumor that at necropsy had metastasized to the liver. In Howard's⁶ review, 19 of 31 patients died within 18 months; however, 6 lived over 48 months, 4 of them living 6, 7, 8 and 16 years respectively. In our case, death occurred 42 months after proof of disease by needle biopsy of the liver. This is in contrast to adenocarcinoma of the exocrine portion of the pancreas where in a series of 100 cases Gullick¹⁷ noted a maximum survival time of only 12 months even after surgery.

In the presence of hyperinsulinism the clinical differentiation between benign and malignant tumors may be difficult; because in the absence of clinical evidence of metastases the usual systemic manifestations of malignant tumor may be masked by the obesity resulting from attempts by the patient to control the hypoglycemic episodes by frequent feedings. In non-functioning carcinomas the diagnosis would be most difficult without the benefits of surgical exploration. In addition, benign and malignant islet cell tumors should also enter into the differential diagnosis of intractable peptic ulcerations, intractable diarrhea and malabsorptive states.

Summary

A case of non-functioning islet cell carcinoma of the pancreas is presented with a four-year history of symptoms and a 3½-year history of proved metastases.

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Skin Deep?

The skin is of course more than just a covering to protect the various organs and prevent them from slopping around and looking untidy. It is, amongst other things, a true mirror of the mind, reflecting the emotional battles and frustrations, to which every individual is unavoidably prone.—R. W. B. Scutt: "The Approach of the Naval Medical Officer Toward Patients With Skin Diseases." *Journal of the Royal Naval Medical Service*, Autumn 1959. Reprinted in the *U. S. Armed Forces Medical Journal*, Vol. 11, No. 11.

An astonishing amount of knowledge will be
needed for the prevention and cure of cancer.

The Epidemiologic Approach to Leukemia

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THE EPIDEMIOLOGIC APPROACH to neoplasms has been relatively neglected. Most available data have involved national populations based primarily on diagnoses from death certificates and are classified only by organ system involved. Analyses of these data show a tendency for some types of neoplasms to occur more frequently, or in some cases less frequently, in specific ethnic groups or in certain environmental situations. Most neoplasms, however, are not so obvious in their distribution and their occurrence may be more accurately described as endemic rather than epidemic. Agents such as irradiation and chemical carcinogens are well-known in their relationships to neoplasia. Carcinogens are widespread in the environment and human genetic characteristics are difficult to define. Therefore, the problem of recognizing definite etiologic agents for all neoplasms is overwhelming.

Intensive Study of Specific Neoplasm

More reasonable perhaps would be the intensive study of a specific neoplasm in a well-defined geographic area in which adequate diagnostic facilities are available. A model epidemiologic survey performed in the Buffalo, New York area¹ involved children 16 years of age

and under who had died of leukemia between 1943 and 1956. There was a definite increase in incidence of leukemia in children of the upper socio-economic groups, and a tendency for occurrence in close temporal-spacial sequences. The authors point out that the distribution is not inconsistent with an infectious etiology, the infectious agent being apparently widespread but of low communicability. *Non-infectious etiologic agents are not excluded by their data.*

The possibility that viruses may be responsible for some neoplasms in humans has intrigued investigators for many years following the successful demonstration of viral etiologies for several animal tumors.² Five decades have passed since Peyton Rous demonstrated that certain sarcomas of chickens can be transmitted by filterable viruses. Recently Burmester, Fontes and Walter³ have shown that the Rous virus may be transmitted from animal to animal by natural means in animals housed together.

Renaissance of Interest

Although mouse leukemias have been investigated extensively for many years because of their resemblance to the human disease, attempts to demonstrate a responsible virus were futile until Ludwik Gross in 1951⁴ reported the transmission of murine leukemia by cell-free filtrates. These brilliant experiments resulted in a renaissance of interest in tumor viruses.

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Sarah E. Stewart^{5,6} expanded the work of Gross and revolutionized modern concepts of tumor viruses by demonstrating that what had at first appeared to be a single agent had the propensity to produce neoplasms of many diverse types—the type produced apparently depending on the “target” organ involved. This “polyoma virus” was subsequently proved to be distinct from that causing leukemia and was shown to be capable of transmission by saliva, urine and feces in animals housed together, many of which developed serum antibodies against the agent.⁷ More startling was the demonstration that the sera of several humans working with these viruses contained neutralizing antibodies to the agent.⁸

Ultimate proof that a virus is responsible for any disease rests in the fortuitous finding of a susceptible experimental animal or the ability of the virus to propagate in cell cultures accompanied by predictable and reproducible cytopathogenic changes. In cases where neither is available, evidence for a viral etiology must be circumstantial; epidemiologic studies many times give valuable indirect evidence, e.g., infectious hepatitis and homologous serum jaundice.

Two Approaches

Thus the solution to the problem of etiologies for human neoplasms rests in two approaches, especially those in which viral agents are suspected. The first involves extraction of an agent from human tissues which will consistently produce neoplasms in animals. Schwartz⁹ demonstrated that extracts from brains of human patients with leukemia accelerated the development of leukemia in AKR mice. Burton, *et al.*¹⁰ reported that leukemia and other neoplasms could be produced in inbred mice of a low leukemia strain (C₃H) by means of extracts of organs and blood from humans with leukemia and Hodgkin's disease. These experiments, while encouraging, do not conclusively prove the relationship between the agent and the neoplasm. If this relationship is established, the mechanism of natural transmission from individual to individual will require clarification. Complete epidemiologic data will be needed.

The conclusion that no single agent is responsible for all neoplasms is inescapable. Complexity of the factors involved points out the need for collection and analysis of detailed data. Re-

lationships of environmental contamination by tumorigenic chemical and physical agents to neoplasms needs to be established, and can be done only by large-scale investigation using the epidemiologic approach.

Pilot Study in Progress

Acute leukemias are appropriate for this type of concentrated study because the course in a typical case is less than six months, and the diagnosis is usually obvious. A pilot survey based on the methods of the Buffalo study is in progress in Indianapolis and Marion County, an area with a population large enough (551,777, 1950 census; 690,162, 1960 census) to yield a low but significant number of cases in a 10-year period (approximately 10 cases per year in the age group 16 years and under). Excellent diagnostic facilities are available in Marion County for individuals of all income groups. The five general hospitals, the Veterans Administration Hospital and those of the Indiana University Medical Center are adequately staffed by hematologists and pathologists who are fairly consistent in their diagnostic terminology.

Through cooperation of the State Medical Association and the Indiana State Board of Health, data from death certificates of individuals who have died of leukemia or lymphomas between 1950 and 1960 are being made available. Additional information may be needed from attending physicians or hospital records. If promising leads are obtained, the study will be extended to include the entire state. The enthusiastic cooperation of practicing physicians in the State of Indiana is essential to the success of this program.

ADDENDUM

After the acceptance of this article for publication, R. DeLong (*J. Lab. Clin. Med.* 56:891, Dec. 1960) reported the production of leukemia in 65-90% of Swiss mice inoculated with cell-free filtrates of bone marrow from human patients with various types of leukemia. None of the uninoculated litter-mates of the inoculated mice developed leukemia nor did any of the controls inoculated with bone marrow filtrates from non-leukemic humans. The author does not claim that the agent is a virus.

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One for the Road

The British Medical Association has been studying the relationship of alcohol to road accidents and has come up with some interesting findings and recommendations. First, "A concentration of 50 mg. of alcohol in 100 ml. of blood is the highest that can be consistent with the safety of other road users." This concentration is likely to be exceeded after two American-sized drinks—which may or may not surprise some.

The rate of absorption is a function of the amount of food in the stomach, as any social imbiber knows. The British make the suggestion of drinking milk for those who must drive after some modest drinking. If fructose is available, it might be added to the milk since fructose has the quality, in the dog at least, of increasing the rate at which alcohol is metabolized. Breath samples are now becoming more accurate, and this BMA report would seem to suggest stronger laws to disqualify the driver who is on the highway "under the influence" in order to protect those who are not.—*Brit. M. J.* 1:256, 1960, reprinted in *G.P.* October, 1960.

Malignant Melanoma in Children

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THE REASON FOR apparently good prognosis of malignant melanoma of skin in children as reported in earlier literature became evident when "juvenile melanoma" was described as a specific benign pathologic entity.¹ This lesion occurs in both children (pre-pubescent individuals) and adults and comprises a large percentage of the previously recorded cases of "malignant melanoma" of skin in children. These lesions, reported as histologically malignant, proved to be clinically benign.

This presentation will discuss the clinical and pathological aspects of true malignant melanoma of skin in children and outline a useful approach to its recognition and management. A documented case with autopsy findings is added to previously reported acceptable cases.

Most pigmented nevi in children have a proliferative component which only rarely results in malignancy. A complete survey of the literature up to April, 1953, by McWhorter and Woolner revealed that a total of 102 cases of malignant melanoma of skin in children had been reported.² Malignant melanomas occurring in newborns were excluded in this survey because these usually had been shown to be metastatic lesions occurring by placental transmission.^{3, 4, 5, 6, 7, 8} Of this group of 102 cases, these authors accepted only 18 as sufficiently

well documented by clinical data, histological description, photomicrograph, or follow-up study to be considered as true malignant melanomas. Many of the less well documented cases were benign juvenile melanomas.

Five of the aforementioned 18 cases were added by these authors. Follow-up data showed that 11 of the 18 had died of the disease, one was living without evidence of metastasis 21 years after surgery, and two had survived three and six years after removal of the primary lesion and regional lymph node metastases. Of the remainder, one patient had regional lymph nodes removed for metastases four years after excision of the primary, one had local recurrence of disease and two had no follow-up.

Since this survey, five cases of malignant melanoma in children have been found reported in English literature. In one case, reported in 1954 by Williams, malignancy developed in two separate areas of a very extensive, congenital, pigmented, hairy nevus of the upper half of the trunk of a five-year-old girl.⁹ Death occurred within five years from extensive metastatic disease. Hendrix, in 1954, documented a case of malignant melanoma in a two-year-old boy.¹⁰

Dobson, in 1955, reported a case of malignant melanoma that developed in a repeatedly traumatized "wart" on the elbow of a four-year-old white male.¹¹ This non-pigmented melanoma had axillary metastases at the time of excision. In 18 months there was a local recurrence. No evidence of recurrence or metastasis could be found nine years after the first excision (seven and one-half years after local recurrence). In

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the same report, a case of malignant melanoma developing in a congenital giant compound nevus on the back of a two-year-old Negro girl was described. Growth of this tumor was not affected by a full course of triethylenephosphoramide (TEPA), or a short course of aminopterin. The tumor recurred, metastasized widely and resulted in death seven months after excision of the initial lesion.

Covers Entire Buttocks

In 1958 Derrick and Thompson reported occurrence of a malignant melanoma in a large, lobulated, hairy blue-black nevus covering the entire buttocks of a four-and-one-half-year-old Negro male.¹² There were multiple hairy and non-hairy nevi scattered over the entire body surface. The child was treated with a colostomy, excision of the large nevus and skin graft at three months of age. He died at four and one-half years of age. At autopsy, an 8 x 10 cm mass of metastatic melanoma was found in the presacral area, together with other visceral metastases.

Case Report

In 1954, a five-and-one-half-year-old boy of Caucasian descent had a pigmented skin lesion removed by sharp dissection from the area of the left posterior axillary fold. This lesion was flat, measured approximately 7 mm in diameter, and had appeared rather suddenly. No pathologic examination was obtained. Four months later, a mass was noted beside the scar. This was removed and microscopic study resulted in a report of a benign pigmented mole. The knowledge of a previous excision was not made available to the examining pathologist. All junctional components and other superficial features which would have raised a serious question of malignancy, had they been present, were obliterated.

In December, 1955, a mass measuring 4 cm was noted in the left axilla. This mass enlarged, and in April, 1956, a left axillary node dissection was performed without entering the tumor tissue in any way. The surgical specimen consisted of a tumor mass 6 x 3 x 2 cm, together with two small lymph nodes and axillary tissues removed from the area proximal to the tumor mass. Also removed was an ellipse of skin containing a previous incision scar. Microscopic examination revealed metastatic malignant mel-

noma in the axillary tissues. The two lymph nodes showed only reticulum cell hyperplasia. The skin scar contained no residual neoplasm. Roentgenograms of the chest at this time were interpreted as normal.

Tumor in Left Axilla

The patient had been without signs or symptoms for several weeks after the axillary surgery, when again, a small tumor was discovered in the left axilla. Clinically, it was not possible to determine whether this was an exuberant scar or a recurrent neoplasm, although the latter was thought to be more likely. In June, 1956, a radical left axillary dissection was performed. Three enlarged, firm, pale tan lymph nodes were encountered in the specimen. Microscopic examination revealed a solitary focus of metastatic malignant melanoma and suture granuloma.

In December, 1956, physical examination at the time of his final admission revealed a mere bony frame of a previously well developed, well nourished child, now eight years old. The child was extremely emaciated with an emphysematous-type chest and a rather protuberant abdomen. Examination of the head, eyes, ears, nose and throat revealed little other than a dry tongue from rapid respiratory exchange.

Chest examination revealed a fluid level up to the third intercostal space on the right. The left chest seemed to contain free fluid also, although breath sounds were present above the sixth interspace. The liver was greatly enlarged to below the umbilicus, and nearly to the iliac crest on the right. The abdomen appeared to contain free fluid. The external genitalia were normal. The extremities were very thin, bony and devoid of subcutaneous fat.

A roentgenogram of the chest three months prior to this admission showed bilateral pulmonary metastases. Roentgenograms at the time of admission revealed an obscuring right pleural effusion, nearly complete atelectasis of the right lung and extensive metastases in the left lung. The hemogram on admission was 12.5 gms of hemoglobin per 100 ml, 3,960,000 red blood cells and 10,200 white blood cells per cubic millimeter, with 80% neutrophils and 20% lymphocytes.

The boy's death occurred after seven weeks of hospitalization from tumor cachexia and respiratory failure.

At the time of autopsy, the body appeared

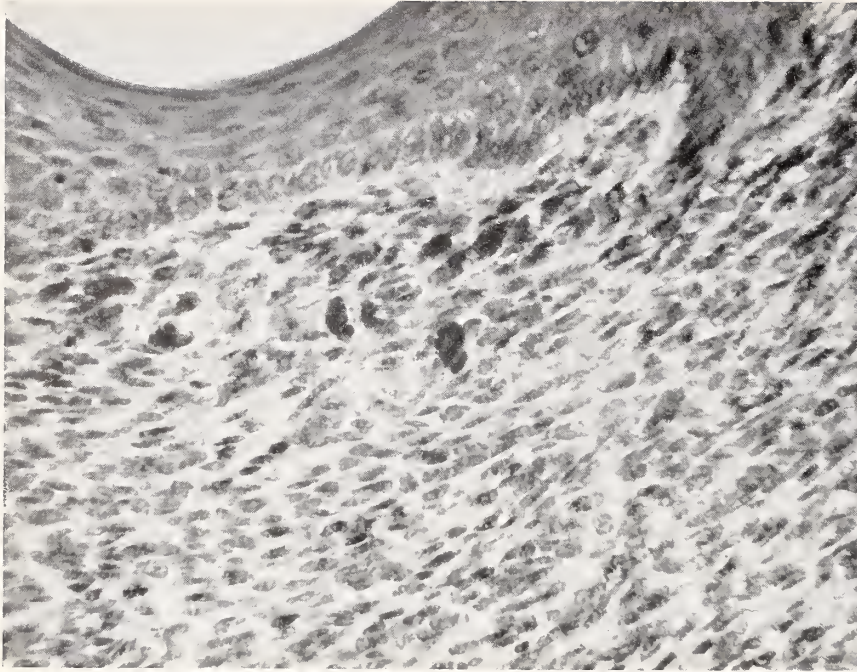


FIGURE 1
SKIN RECURRENCE. The spindle cell pattern predominates. Junctional nests were obliterated by the previous excision. Dark melanin pigment is present in superficial cells. Hematoxylin and eosin, 100X.

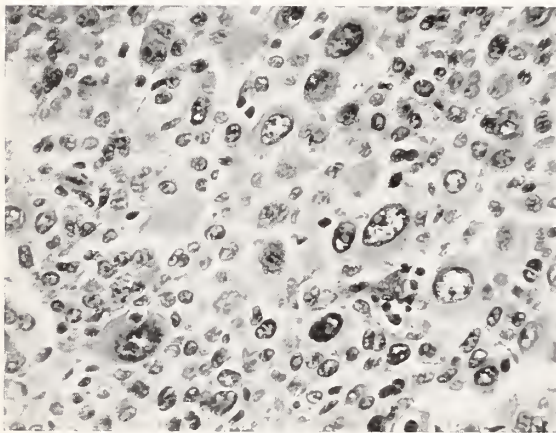


FIGURE 2

AXILLARY LYMPH NODE metastasis. Typical pleomorphic melanoma cells with abundant "ground glass" cytoplasm and anaplastic nuclei with prominent nucleoli. Pigment not visible. Hematoxylin and eosin, 400X, reduced $\frac{1}{4}$.

normally developed but extremely emaciated. The right hemithorax appeared distended when compared with the left. The abdomen was distended. Other than a 5.5 x 4 cm fixed left axillary mass, no lymphadenopathy was externally palpable. In the mediastinum and right anterior chest were massive areas of neoplasm which required separation from the breast plate before the thoracic contents could be exposed. The pericardium was distended by over 100 cc of clear amber fluid. Neoplastic metastases were present on its visceral surface in the

region of the great vessels, and its parietal surface on the right. His heart was soft, small and atrophic (63 gms—normal 110 gms). One metastatic focus was located in the left ventricular endocardium. The thoracic aorta passed uncompromised through the neoplasm which partially surrounded the superior vena cava and innominate vein and completely surrounded and compressed the inferior vena cava.

The diaphragm was depressed by neoplasm. There was marked mediastinal and cardiac shift to the left. The left lung was collapsed and contained multiple metastases. The right lung lay centrally in a huge neoplastic mass and could be identified as atelectatic lung parenchyma only after the mass was bisected. There was extensive involvement of all areas of the parietal pleura bilaterally. Although the trachea was surrounded by neoplasm, the mucosa was not invaded.

The liver was enlarged (850 gms—normal 736 gms) principally due to congestion. Multiple metastases were present measuring up to 2 cm in diameter. The spleen was enlarged by congestion (100 gms—normal 69 gms). The urinary bladder was distended. The esophagus was surrounded by neoplasm. There was gaseous distention of the stomach. One of several pancreatic metastases was seen invading from the region of the tail of the pancreas into the colon at the splenic flexure. The mucosal surface,

however, was intact. Small metastatic foci were found in both kidneys. The thyroid appeared atrophic. Mild cerebral edema was present. Metastases were found in the mediastinal, peribronchial, retroperitoneal and left axillary nodes. No recurrence could be demonstrated in the skin scar.

Microscopic study of tissue sections confirmed the gross impressions. In addition, cerebral congestion with mild perivascular hemorrhages was seen. The original skin tumor of the left posterior axillary fold skin (which, in actuality, was the first recurrence) had a predominantly spindle-cell pattern. The main body of the neoplasm was intradermal with only close approximation to the basal layer. Cellular anaplasia was present with nuclear pleomorphism, dense chromatin clumping, dense nuclear membranes and somewhat prominent acidophilic nucleoli. Pigment could be found in melanoma cells, usually near the basal layer of the epidermis. Numerous mitotic figures were present. In retrospect, this latter feature was the only definite indication that the lesion was malignant until metastatic neoplasm was removed and diagnosed as malignant melanoma.

Similar Tissue Patterns

Microscopic sections of organs bearing metastases revealed similar neoplastic tissue patterns.

These were quite similar to those seen previously in the axillary lymph nodes first removed following excision of the initial skin lesion. The melanoma cells were somewhat more rounded or polyhedral than those seen in the skin lesion. Pigment was present in scattered areas. This was Prussian-blue negative. Occasional groups of cells were quite pleomorphic in appearance and contained bizarre neoplastic giant cells. The neoplasm seen in the skin recurrence and throughout the body in this case was characteristic of malignant melanoma and indistinguishable from malignant melanoma in an adult.

The following general classification of pig-

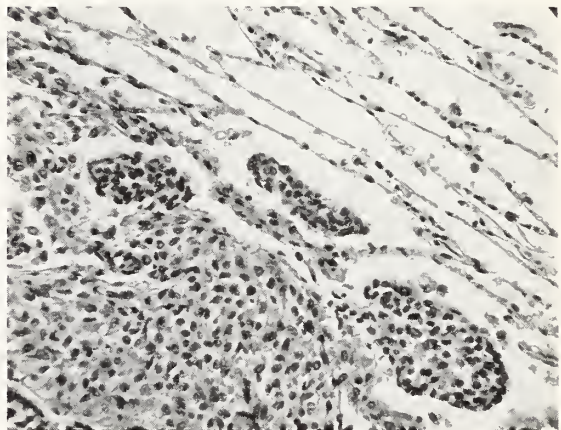


FIGURE 3
PULMONARY METASTASIS. Hematoxylin and eosin, 100X, reduced 1/4.

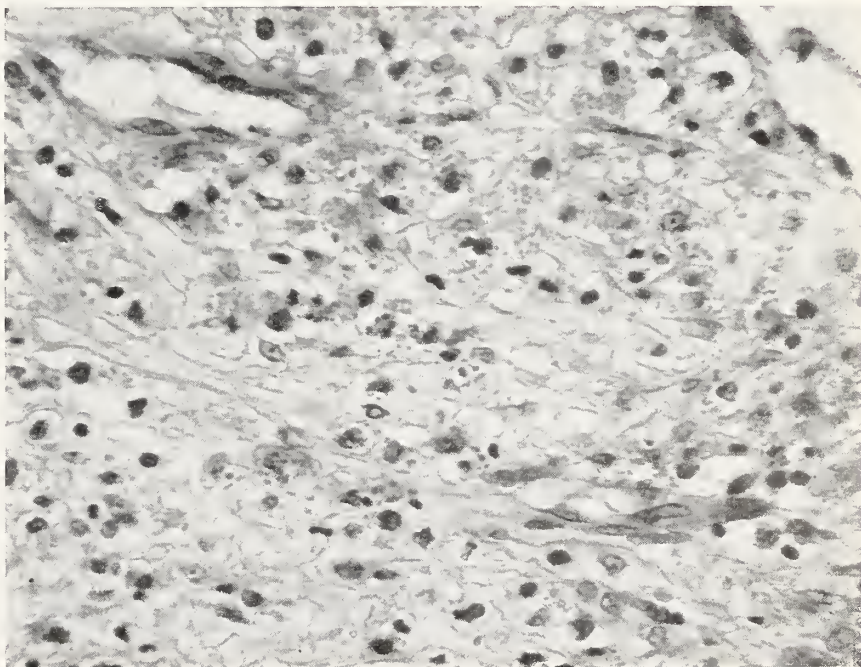


FIGURE 4
AXILLARY METASTASIS. Melanin pigment granules present in degenerating melanoma cells. Hematoxylin and eosin, 100X.

mented nevi and malignant melanomas has been proposed by Allen and Spitz:¹³

Benign Pigmented Nevi

- a. Junctional nevus*
- b. Compound nevus*
- c. Intradermal nevus
- d. Blue nevus*
 1. Mongolian spot
 2. Nevus of Ota
- e. Juvenile melanoma

Malignant Melanomas

- a. Melanocarcinoma [malignant melanoma]
- b. Malignant blue nevus

The junctional nevus (and the junctional component of the compound nevus) is the source of all malignant melanomas of skin and mucous membrane, the blue nevus excepted. It is usually difficult to clinically recognize lesions which have junctional activity histologically demonstrable.

Aids to Differential Diagnosis

The following is useful information, in part derived from unpublished data of Shaffer and previously cited by Beerman, Lane and Shaffer which aids the clinician in differential diagnosis:¹⁴

The junctional nevus is a flat or slightly elevated, usually speckled or mottled, poorly defined nevus that appears early in life, frequently in crops. This nevus evolves into either the compound or intradermal type except when it is in the skin of the palms, soles or genitals, where it may persist as a junctional nevus throughout life.

The compound nevus is nearly always elevated and often has a macular ring at its periphery. It may appear verrucose, keratotic, polypoid or sessile, or with any combination of these features.

The intradermal nevus has the same variations of appearance as the compound nevus.

The benign juvenile melanomas may often be purplish-red rather than dark brown which is characteristic of compound or intradermal nevi. They tend to be hairless, larger and more elevated than the usual childhood nevus.

The blue nevus usually appears as a smooth, discrete 2-10 mm pigmented lesion. It is usually solitary. The color may be blue-black, steel blue, gray, brown or yellow depending upon its location and depth in the skin. Approximately one-

half of the blue nevi are located on the dorsum of the hands or feet. Blue nevi need not be apparent at birth. Only twelve malignant blue nevi had been reported in the literature prior to 1954.¹⁵

Unless ulceration has obscured histological patterns, the juvenile melanoma and malignant melanoma in children can be differentiated in almost all cases. Admittedly, the accuracy in histologic identification of any lesion improves with the increased experience of the pathologist. However, with regard to the pigmented skin lesions, there are combinations of cytological and histological features that *per se* suggest the identity of the lesion.

The histologic features of the juvenile melanoma were originally described by Sophie Spitz in 1948 and later listed by Allen and Spitz as follows:¹³ "(1) the relative superficiality of the essential landmarks of the lesion; (2) the two elements of a compound nevus, junctional and intradermal; (3) edema and telangiectasia of the cutis just below the epidermis . . . ; (4) the tendency for single cells or compact nests of spherical or spindled cells to be segregated sharply from adjacent ones . . . ; (5) the occurrence of large cells with abundant, usually uniformly basophilic, myogenous-appearing cytoplasm . . . ; (6) the superficially located, characteristic giant cells, those with the single large nucleus, as well as the multinucleated ones resembling the pattern either of the giant cells of measles or of Touton giant cells, with a complete or incomplete peripheral rim of small nuclei . . . ; (7) the generally abrupt transition between the acantholytic, loose junctional cells and the still intact adjacent epidermis . . . ; and (8) the relative sparsity of pigmentation. . . ."

The malignant melanomas in children show histological patterns of excessive virulence of cellular anaplasia with nuclear pleomorphism, hyperchromatism, variable clumping of nuclear chromatin and increased thickness of nuclear membranes, variability of amount of cytoplasm and increased numbers of mitotic figures. These, combined with a lack of the above described characteristic features of the juvenile melanoma, designate a malignant lesion. The malignant melanomas in children and adults are almost histologically inseparable. Some authorities have reported that they believe these lesions are essentially the same.

* Capable of becoming malignant.

Which Lesions to Remove

Since the clinical features of the above described pigmented lesions and those with early malignant change are similar, it is apparent that a guide is necessary to help determine which pigmented skin lesions in children should be removed surgically and examined histologically. The following list modified from Cunningham as reported and modified by Beerman is recommended as such a guide for the clinical management of pigmented skin lesions in children, as well as in adults:^{14,16}

1. All pigmented lesions of the soles of the feet, palms of the hands and genitalia.
2. All ulcerated pigmented lesions.
3. Those pigmented lesions which are subject to chronic irritation by reason of their anatomic location.
4. Pigmented lesions with irregular borders, pigmented finger-like projections or with accompanying satellitosis.
5. Pigmented lesions which have shown an increase in pigmentation or size or a decrease in hairiness or which are accompanied by the appearance of unexplained regional lymphadenopathy.

If a true malignant melanoma is discovered in a child, the treatment should be removal of the greatest possible margin of skin together with the lesion. Local recurrences have been at the rate of 20%.¹⁷ This appears to result because this lesion is usually no more widely excised than squamous cell or basal cell carcinomas of the skin. Allen and Spitz believe that most local recurrences are not due to lymphatic or venous spread, but are due to the development of new junctional foci in the adjacent skin. For this reason, wider excisions and skin grafting will usually be more beneficial than deeper local dissection for the prevention of local recurrence. The question of prophylactic regional lymph node dissection has been variously decided by different authorities. We feel that only in cases of clear-cut lymphatic drainage patterns to one surgically accessible area should consideration of this radical surgery be entertained.

Summary

The clinical and pathologic aspects of true malignant melanomas of skin in children and its differential diagnosis from common benign pigmented skin nevi have been presented. Clinical

management has been discussed. A review of the literature is given with clinical and pathologic documentation of an additional case.

ACKNOWLEDGMENT

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Neurogenic Ossifying Fibromyositis in Paraplegia: A Case Report

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THIS CONDITION has been variously referred to as neurogenic ossifying fibromyositis, myositis ossificans neurotica, para-osteal arthropathy of paraplegia and soft tissue calcification of paraplegia.

In 1919, Dejerine outlined the characteristics of neurogenic ossifying fibromyositis in paraplegia as:

1. Always appearing below the level of the cord lesion;
2. The joints of predilection being about the hip joints, the medial femoral condyle and the knee joint. The joints proper are not involved;
3. The calcifications may be single or multiple.

The reported incidence in paraplegia varies considerably in various reports but, on an average, is found in about 40-50% of patients with complete paralysis. Soule reported ossification in only three cases of 27 showing improvement, as compared to 20 of 35 cases showing no clinical improvement. The incidence is higher (75% or more) in lesions of the cervical cord.

Abramson says soft tissue ossification may begin to appear as early as 20 days following injury, progress to a certain point and then remain stable. In other neurological conditions in which similar calcifications occur, the progress of calcification tends to continue as long as the lesion progresses.

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Obscure Etiology

The etiology of neurogenic ossifying fibromyositis in paraplegia is obscure. Even more puzzling is why this condition affects some patients and not others. Soule and Stiff reported that there was no apparent relationship between neither the occurrence nor the degree of involvement and the severity of the preceding injury, site of the neurological lesion, time of operative treatment, presence or absence of decubitus ulceration, presence of a urinary tract infection, any associated injury or infection, age of the patient or the blood level of calcium and total proteins.

The average blood phosphorus and alkaline phosphatase levels in Soule's cases without calcification were 3.9 mg.% and 5.2 B L units, respectively, while the average in those with calcification were 4.7 mg.% and 6.2 B L units, respectively.

Early roentgenographic findings are those of a fluffy para-articular calcification which gradually progresses to a more mature trabeculated bone.

This case is presented because of the striking clinical and roentgenographic findings.

Case Report

A 19-year-old white male sustained a compression fracture of the sixth thoracic vertebra May 19, 1957, with immediate sensory loss below the T-6 level and complete motor paralysis of the abdomen, hips and legs. He showed return of sensory function within a matter of hours. The first to return were those modalities carried in the posterior columns (position, vibratory, tactile

sense) and later a patchy return of the long lateral tracts (pain and temperature). Within a few days, he showed return of motor function in the abdominal musculature, and within two weeks, there was a spotty return of motor power in the legs, more marked on the right than on the left. He gradually became ambulatory with bilateral long-leg braces and Canadian crutches.

Fourteen months after injury, the patient had a spastic paraparesis with more involvement on the left than on the right. Reflexes were bilaterally present and equal. There was a Babinski response bilaterally with the left being more marked and also showing a withdrawal response. There was voluntary muscle power in all right lower extremity muscle groups, ranging from fair to normal. On the left, there was spasm with some voluntary response of the muscles down to the level of the knee. Position sense and localization was impaired in the left toes.

Touch was intact over the entire right side and on the left, also, down to the sole of the foot. There was hyperalgesia below T-10 bilaterally. The incision of a cyst of the spinal cord at the level of T-6 in July, 1958 caused further relief of bladder spasm and the spasm of the left lower extremity. By October, 1958, the patient was able to walk with Canadian crutches without braces.

Progressive Limitation

Because of progressive limitation of motion of the hips and pain in the left hip, the patient was seen in the orthopedic clinic in August, 1959.

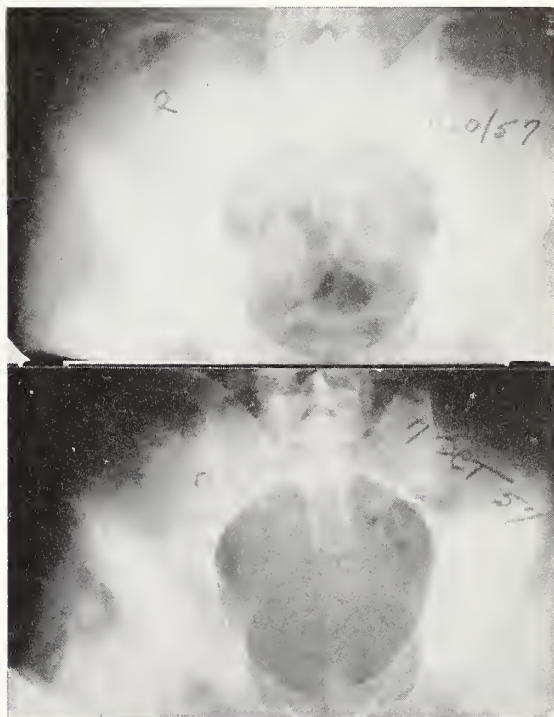


FIGURE 1

THE LOWER PORTIONS of KUB's taken on July 20, 1957 and Oct. 7, 1957, showing early calcium deposits about both hips.



FIGURE 2

AP OF THE PELVIS showing marked para-articular calcification about both hips. Note normal appearing joint spaces.

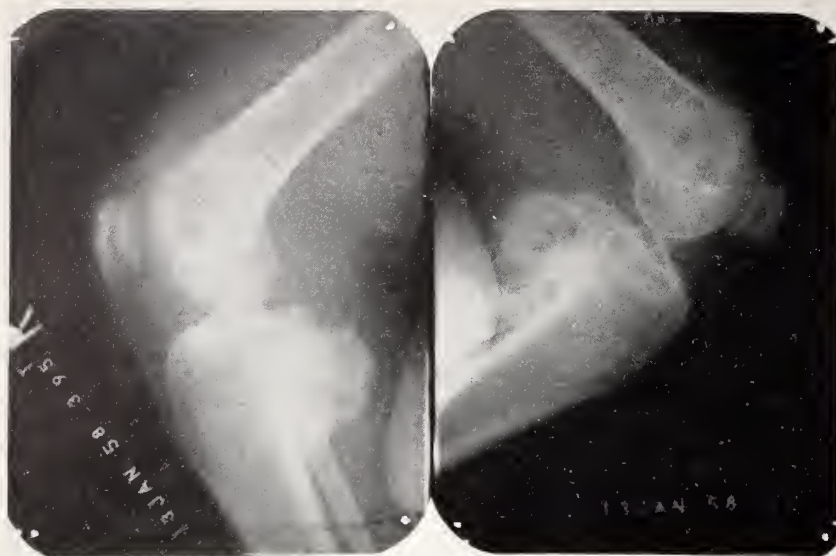


FIGURE 3
LATERAL X-rays of both knees showing calcium deposits.



FIGURE 4
LATER ROENTGENOGRAM showing the more mature, trabeculated bone formations about both hips.

He walked with a swing through gait on his crutches. Spasm of the lower extremities was minimal and there was active muscle power of all lower extremity muscle groups. Examination revealed bony hard masses in both popliteal spaces below the joint line. A bony hard mass was also found about the left hip from just below the anterior superior spine of the ilium distally, to about three inches below the tip of the greater trochanter, posteriorly, and laterally al-

most to the ischial tuberosity and superiorly, almost to the crest of the ilium.

A similar mass was palpated about the right hip but it was not quite as large. There was no detectable motion in the left hip with 15 degrees of fixed flexion contracture. The range of motion of the right hip was found to be from 120-160 degrees flexion-extension, 15 degrees of abduction, 10 degrees of adduction and 15 degrees each of internal and external rotation. The range

of motion of the right knee was from 180-75 degrees. No surgical or conservative means could be offered this patient which would improve his left hip. He was told to actively move the right hip and both knees through their entire range of motion every day to try to preserve the remaining motion.

The serum Ca was 10.6 mg.%, the serum Phos. was 4.1 mg.% and the serum Alk. Phosphatase was 6.9 mg.% on Aug. 19, 1958.

Abnormal Calcium Deposits

The first roentgenogram taken which showed the abnormal calcium deposits in this patient was a KUB taken July 27, 1957. Another KUB, Oct. 19, 1957, showed further condensation of the calcium mass. (Figure 1) Roentgenograms of Jan. 13, 1958 demonstrated the marked par-articular calcification about both hips, and also behind the proximal ends of both tibia. (Figures 2 & 3) A later film of Feb. 13, 1959 shows the further trabeculation of the bony deposits and clearly demonstrates why there is limitation of motion in both hips. (Figure 4)

In this patient, there was extensive calcification about the hips and marked limitation of motion with some apparent progression, especially of the latter, in spite of early clinical improvement and physical therapy. Marked disability of this patient caused by the calcifications overshadows an otherwise happy end result. Serum phosphorus and alkaline phosphatase levels fall in the range reported in Soule's patients who developed calcification. Admittedly, no early determinations are reported.

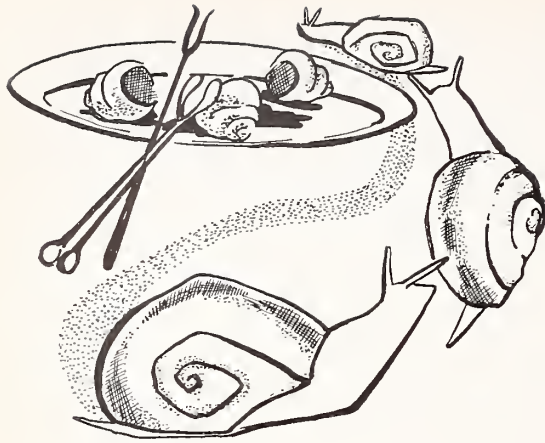
It is hoped that with greater awareness of the occurrence of this condition in paraplegics that more study of the calcium and phosphorus metabolism in the early stages of paraplegia will be done. Further study or report of experiences not yet reported in the realm of physical therapy and other forms of suggested therapy in this condition are needed.

Summary

A discussion of neurogenic ossifying fibromyositis in paraplegia is presented. The case presented shows marked ossification of the tissues about both hips, and moderate deposits behind the proximal tibia bilaterally.

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The Case of the Colombian Snail Connoisseur

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GREGORY MACHÉTE'S first appearance in our office was perfectly routine. Throughout the 65 years of his life he had been remarkably healthy. However, just the day before, he had helped his son lift a heavy weight; he had felt a sudden sharp pain in his groin; there was a palpable, reducible lump there; he suspected a hernia; he had come for an examination.

The usual routine once-over revealed a very wiry, alert individual appearing much younger than his stated age. He was only 64 inches tall, weighed 142 pounds, was well-muscled, very cooperative and in no distress whatever. The obvious right indirect inguinal hernia was easily reducible. The patient was told that he could be fitted with a truss, but that because he was so vigorous and youthful in appearance, surgery seemed to be indicated.

The chart carried the notation that, surprisingly enough, the blood sugar was 190 and the routine urine specimen had a heavy trace of sugar in it. A suitable diet plus one diabinese tablet daily cleared the urine and produced a blood sugar of only 95. Accordingly, he entered a hospital and was operated upon for the hernia. The surgeon experienced no difficulties whatever and the patient went home after the usual minimal hospital stay.

Postoperative Diarrhea

At an office examination, three weeks after the operation, it was noted that Mr. Machéte had lost much weight, being now only 120 pounds. Questioning revealed the fact that he had had

some diarrhea continuously since his return home. There did not seem to be any connection between this and either the controlled diabetes or the hernial repair. The surgeon did a careful proctoscopy, which produced nothing abnormal. Complete gastro-intestinal x-rays were non-contributory; neither the barium enema nor the esophagus and stomach showed a thing. An Ewald meal did reveal a very low acidity; the surgeon did an esophagoscopy and also studied the stomach through a Schindler tube; nothing abnormal. However, the diarrhea persisted; the surgeon and the generalist who had seen him first were progressively less and less happy with what they could not explain. I was asked to evaluate the patient.

I shall long remember my first contact with Señor Machéte. Very few men in this great United States of ours greet another man by means of a courtly bow and a click of the heels. Señor Machéte did just that; with him, it seemed neither affected nor effeminate—just completely natural. His English was limpid pure, having just that delightful piquant foreign accent retained by all persons learning the language as adults. While taking the history and chatting with him during the physical examination, I acquired some knowledge of his background.

A Proud Grandee . . .

He had been born in the Colombian highlands in the valley of the Cauca river not far from the city of Medellin. His family had a large estate there, the original grants going back to the Conquistadores. As a grown man, he had moved down to the lowlands of Bolivar province where the Cauca flows into the great Magdalena

river; he owned another estate near a center called Magangue; this city is only some 100 miles from the Caribbean Sea. Señor Machéte's family was deeply involved in the civil strife between the liberal and conservative parties; being a proud grandee, he had been an active participant in the fratricidal struggles.

In the middle thirties, the position of his side was so enfeebled that it became advisable for him to leave the country. Actually, he had been lucky to have been able to take his wife and son as well as considerable capital to the Yanqui shores; many of his immediate friends had been less lucky, being stripped of either wealth or life! Señor Machéte had come to New York, mingled with his fellow exiles, acquired a great admiration for American democracy and had gone on to become an American citizen.

I completed my examination of the patient. The previous findings were confirmed. In addition, I was quite surprised to be able to palpate the liver a good two fingers below the costal margin. The edge was rock hard and not quite smooth; there was no tenderness. In good light, the sclerae were not yellow but did seem to have that sub-icteric tint of "muddy." Percussion of the chest confirmed unequivocally the fact of liver enlargement in all its dimensions. The conversation with the patient was given a new turn. Had Señor Machéte ever gone wading in the creeks and rivers of Colombia? Most emphatically, yes! He was an ardent fisherman and a snail fancier. . . . "A what?" Yes, he had raised snails as a hobby. "As a food?"

"Oh, yes! they *are* delicious."

HIS Snails Were Clean

Señor Machéte went into ecstatic details. Did I know that the mollusc phylum comprised all the animals with shells; was I aware of the fact that the class of gastropods comprised some 40,000 species; did I realize that the edible snail, *Helix pomatia*, was raised not only in Colombia but also in the region around New Orleans and that they could be bought regularly in the right New York markets? . . . I pleaded ignorance to all these interesting facts, but I did ask him whether he was aware of certain liver flukes parasitic to man that were obligatory snail parasites in their life cycle. Oh, yes—of course. These trematodes, however, pass part of their life in various species of *Isidora* and *Planorbis*; HIS snails were absolutely clean of such abomi-

nations; he tested them regularly for all imaginable contaminants. Señor Machéte brushed off such ideas by an eloquent wave of his well-manicured hands.

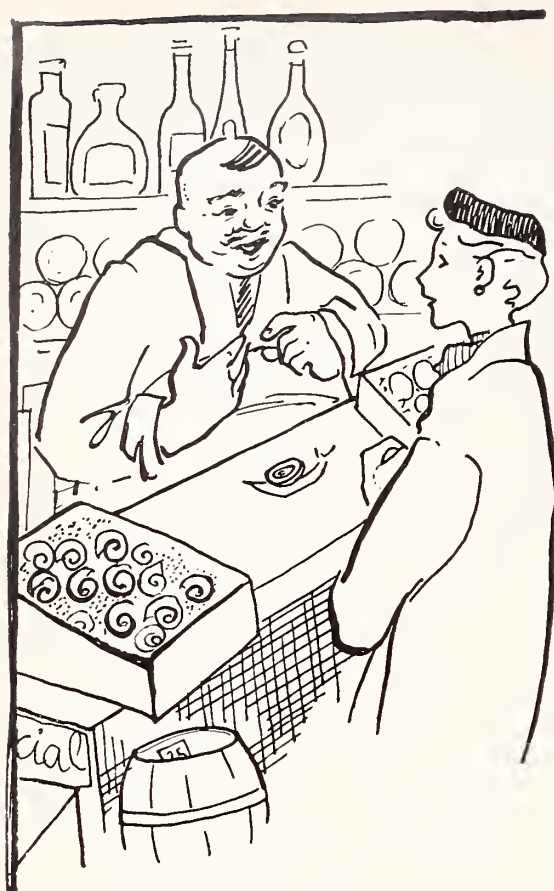
My interesting patient then launched into a discourse on another class of molluscs, namely the cephalopods; they include the giant squid, the largest invertebrate animal known. Its body may reach a length of 19 feet; the tentacular arms, 35 feet; making the total length of over 50 feet. It was quite obvious that Señor Machéte, entirely apart from his political affiliations, was a real, self-taught zoologist, possessing a truly encyclopedic knowledge of the mollusc phylum in general and of the edible snail (and other gastropods) in particular. Still, the more I listened to him, the more did *my* mind stray into that single channel: why this recent liver enlargement associated with the diarrhea?

The Vim-Silverman needle is a useful gadget, easy to use. The liver biopsy was simplicity itself; the long core was dropped into 10% formalin for hardening and later microscopic examination. The patient also submitted quite cheerfully to having some blood drawn for the usual battery of liver function tests.* A mild constipating preparation was given to Señor Machéte and he was asked to return at the end of the

*There is a multiplicity of liver function tests; however, Brauer (in his volume on *Liver Function*) has a splendid discussion of the really essential ones. They may be listed as follows:

- (1) Prothrombin time and cholesterol mirror the function of *synthesis*;
- (2) Serum bilirubin and allied tests mirror the function of *excretion*, indirectly telling us as to whether *obstruction* leading to *jaundice* exists;
- (3) Biopsy and the clinical course reflect the function of *regeneration*;
- (4) Flocculation tests (such as *zinc turbidity*) and analysis of the gamma globulins mirror the extent of *inflammation*;
- (5) Serum glutamic oxalacetic transaminase (SGOT, as usually abbreviated) rises as enzymes are released. Thus, this test reflects the amount of *necrosis*. It rises, of course, with myocardial infarction, but the readings with genuine liver destruction attain maximal levels;
- (6) Biopsy and physical confirmation of a swollen liver mirror the extent of *edema* present;
- (7) Alkaline phosphatase and some of the tests already named aid greatly in estimating the amount of *hypoxia* present.

For the reader desiring a more compact two-page summary, Dr. Wm. G. Bernhard presents such a capsule on pp. 23-24 of the *Seminar Report*, Summer 1960.



week when the results of the various tests would be available.

Hunch Pays Off

The liver function tests showed border-line *obstructive* jaundice; the alkaline phosphatase gave a rather jarring reading of 22 Bodansky units. The results of the biopsy were more than gratifying: the hunch had paid off! Well encapsulated *SCHISTOSOMA MANSONI* were present—in profusion! It was the discussion by Señor Machéte on the finer aspects of the gourmet approach to snail consumption that had guided my thinking about the well-known cycle of the tiny 0.16 x 0.06 mm oval eggs hatching in water, the miracidia entering the snails to grow into sporocysts, dividing and changing to cercariae, which in turn swim freely in the water where they attach themselves to the bare skin on the feet of waders, burrowing their way to the human circulation, and thus, finally, finding their way to the liver where they grow into the adult trematodes. From the liver, the parasites travel via various veins to the urinary bladder and the rectal mucosa. The cycle is completed

when the trematode is passed by the human host in his excreta thus recontaminating the soil and the streams of water carrying the burden of drainage.

The diagnostic coup, for all its positive implications, was still, somehow, out of focus. After all, the patient had been away from Colombia for a goodly score of years. Could he have ingested infected snails right here in New York? Possible—but then, why did a careful series of gastro-intestinal studies reveal no traces of ova or parasites? It was possible to have no bladder symptoms either, true enough—but why then was there a minimal eosinophilia only? What about the puzzling diabetes? Why the persistent diarrhea in the total absence of any proctologically demonstrable pathology? Where did the high alkaline phosphatase come in? What was the REAL significance of this suddenly enlarging liver in the previously vigorously healthy individual? We could be certain that the herniorrhaphy had had nothing to do with it.

Regardless of the unanswered questions, it was a certainty that Señor Machéte was entitled as a minimum to hospitalization, vigorous antimony therapy and meticulous recording of his further course. This was done; tartar emetic was given intravenously in maximal dosages; Fuadin intramuscularly was pushed to the limit; forced high caloric feeding made him gain 10 pounds—not forgotten were daily stool cultures, a repeat proctoscopy and a meticulous cystoscopy.

Charms One and All

Within three weeks, the diarrhea was checked—our patient began to feel much better. However, the liver edge did not go down much, if any. It was impossible, also, to wave away a white blood count persisting around 14,000 and an eosinophilia rising from a trifling 3% to a very ominous 10%. . . . During his stay in the hospital, Señor Machéte charmed one and all with his exquisite manners, unflagging cheerfulness and constant self-abnegation while extending what help he could to others. Also, he turned out to be an excellent chess player; he invariably spotted me a piece and still managed to mate me with disconcerting ease!

Consultations were sought with assorted ologists. Señor Machéte was sent to the Parasitology Clinic of the New York City Board of Health; several trips to their place added nothing to the picture as presented. A couple of

repeat liver biopsies again showed the trematodes in profusion, but "liver lobules intact and portal areas were unexceptional." We were still in the cleft stick of our diagnostic dilemma: There was SOMETHING very wrong—but just *what*? Pancreatic parasitization was possible but unproven. Neoplastic obstruction around the sphincter of Ruggero Oddi involving the ampulla of Vater was a grave possibility; in fact, we were toying with the idea of an exploratory laparotomy but were deferring this until we could see how much relief would be obtained from the trivalent antimony (and other) therapy.

Summoned to Family Hacienda

At this very time, Señor Machéte received some very important telegrams and long-distance calls from Colombia. The old dictator, Rojas, had been tossed out; there was a general amnesty; as the senior surviving Machéte, his clan was demanding his immediate presence at the old family hacienda: the numerous Machéte estancias had to have the ranking estanciero preside over a family gathering determining their further course and disposition. I was glad to see him feeling well enough to be flying to his native land. As I sat by his hospital bed discussing his forthcoming trip, Señor Machéte again startled me most unforgetably. He leaned forward and placed lightly on my knee his exquisitely manicured hand; he spoke quietly and earnestly.

"I am most grateful to all you doctors for having made it possible for me to travel; I certainly want to see the house where I was born; but I WILL come back to die here in New York—my time is almost up!"

So I had not fooled him one little bit! Was it bedside blundering by the various attendings? Did we communicate our unease via ESP, extra-sensory perception? I did brace myself and attempted my most professional, authoritative reassurance—it was no go! He leaned forward again and started to console me.

"You doctors have all tried SO hard but I just know that things in here"—he pointed at his right upper quadrant—"are ALL wrong; I don't think I'll be here for Christmas. Still, I will make the trip, arrange things, have a last look at Colombia and then come back here; THIS is my country now."

The courtly cavalier spoke with all the Old

World grace to be expected of a Castilian grandee. There was no fear or bravado in his demeanor—only the quiet fatalism to be seen in a kinsman of Cervantes and Goya. Completely detached, he was sympathizing—almost apologizing—anyhow, communing with the doctors who had really tried—and failed! I clasped his hand and wished him *bon voyage*; silence was more becoming to me!

Within six weeks I had a telegram asking me to arrange for an ambulance to meet the plane on which Señor Machéte was returning; would I please be there and personally escort him to the hospital? What I beheld at the airport was truly distressing: the patient was lying on a bed, propped up on pillows, orthopedic, jaundiced and absolutely gaunt. The hand that was extended to me was lifted with an obvious effort. There was marked ascites and massive edema of entire body below the diaphragm. Even a cursory exam at the hospital confirmed the obvious Inferior Vena Cava Syndrome.*

Taxed Beyond Limit

The patient had had a most wonderfully satisfying and enjoyable trip; he had taxed himself to the limit—and beyond; now he was at the end of his tether.

Remarkably enough, the liver had not enlarged much; it was the marked ascites plus the general wasting that had made the abdomen bulge so prominently. Enough ascitic fluid was withdrawn to make Señor Machéte more comfortable. He was digitalized intravenously and given enough sedation to be relieved of all pain. The surgeons and other consultants agreed that our Colombian grandee had deadly trouble in the right upper quadrant. It appeared that there was a neoplasm (pancreatic?) that was spreading its tentacles around the common bile duct, squeezing the inferior vena cava shut and otherwise destroying tissues vital for life.

* While not common, the literature is replete with illustrative cases. The following references are typical:

- (1) M. J. Greenberg and D. McC. Gregg: Thrombosis of the Inferior Vena Cava. *Postgraduate Med. J.*; London, England, Vol. 35:408, pp. 580-582.
- (2) Clinicopathological Conference: Inferior Vena Caval Occlusion. *Am. J. Med.*, April 1960, Vol. 28:4, pp. 593-605.
- (3) A. G. MacIntyre: A Case of Amyloid Goitre and Inferior Vena Cava Thrombosis. *British J. Surgery*, Nov. 1958, pp. 260-264.



Surgery a Desperate Gamble

Were we justified in an exploratory laparotomy? First, we might make the patient more comfortable; second, it just might be that he was suffering not with a fatal carcinoma but was having trematodes multiplying in the wrong places—in that case, surgery could be curative. The consensus was that the surgeon would probably not be able to cope with the extensive lesions that had to be there. We decided to be completely frank with the courageous patient and his family. Quite baldly, we stated that, while surgery seemed to be the only possible chance, the best that we could promise was a desperate gamble.

Señor Machéte listened gravely; his manners and courteous demeanor could have been those of a Grand Monarch holding an audience. Could he defer an answer until the next day? But, of course. He leaned back on the pillows and requested a priest, "I've had extreme unction last week back in Colombia but, as a practicing Catholic, I think I need his attentions. In the meantime, my dear doctor, would you play a game of chess with me? . . ."

What were the inner sources of this remarkable man's stamina? He had had himself freshly shaved and powdered; as an immaculate hand reached for a piece on the board, we talked—or rather I listened as Señor Machéte told me about

his trip to Bogota, the boat ride down the Cauca river to his family estates, the incredible reconciliation between the formerly feuding liberals and conservatives, the dangers of Communism—the conversation ranged far and wide—also, before the priest had the time to arrive, my pieces were hopelessly beaten so that I could resign with a graceful mien when I saw the robed Dominican approaching.

That evening, I dropped in as the patient was being tucked in for the night. Señor Machéte thanked me for the fine game I had given him (I really hadn't), thrust out his arm for the one-fourth grain of morphine hypodermic that the nurse was preparing to give, courteously bade me good-night, turned over and went right to sleep.

Our patient slept well all night. About 6:00 a.m., the special nurse noticed that the patient gave a deep sigh—and ceased to breathe. As happens so often in these cases, Señor Machéte had expired as quietly and courteously as he had lived. The hernia had been repaired just six months (less two days) previously.

Still Unanswered Questions

The autopsy confirmed most of our speculations but did not give all the answers. Primary carcinoma of the head of the pancreas was there; its tentacles reached out in all directions, enfolding the inferior vena cava, squeezing the common bile duct and spreading along Glisson's capsule as well as into the liver substance. Most of the microscopic sections revealed only long-dead, calcified trematodes. However, especially in the pancreas, there were quite a few relatively fresh cysts; some *living*, mating organisms were recovered! The pathologists were not willing to assert that the cancer was the result of the chronic irritation from one of these. Were the living schistosomes merely newly ingested organisms carried within recently consumed snails? The answer was a probable but not categorical yes. Why had repeated studies of the bladder and the g.i. tract yielded no traces of the trematodes? Did the occlusion of the inferior vena cava supply the answer? Again, an equivocal maybe. From a strictly epidemiological standpoint, the case still had unanswered questions.

Personally, however, I treasure most highly a letter sent to me by the junior Machéte a week

or so later. I quote in part, "Prior to my father's death, he had often commented on the deep and earnest interest with which you attended his case. In my few talks with you and during our brief acquaintance, I came to realize that his high regard for you was well-founded. In the absence of my father, may my mother and I extend to you our most profound thanks."

The medical profession had done absolutely nothing for Señor Machéte; I and my colleagues had fumbled the case rather badly. Yet, I sel-

dom had anything more rewarding in human experience than my contacts with the Machéte family. Wherever you are, my Colombian snail connoisseur, let me stand up and drink to your memory the Spanish toast you taught me,

"Salud y pesetas y amor y tiempo por gustarlos!"

Health, money, love and the time to savour them.

1270 Fifth Ave.

New York 29, N. Y. ◀

1960 Was A Good Health Year

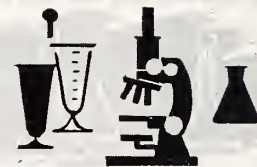
Despite a poor start, 1960 proved to be a good health year for the American people, according to the statisticians of the Metropolitan Life Insurance Company. Record low rates were established for infant and maternal mortality and for tuberculosis.

The death rate in the United States for 1960 is estimated to be 9.4 per 1,000 population, the thirteenth year in succession to register a rate below 10 per 1,000. The mortality rate was the same as that for 1959 and only 2% above the all-time low recorded in 1954.

Infant mortality in 1960, for the first time in our history, dropped below 26.0 per 1,000 live births, the statisticians report on the basis of information now available. The previous low, 26.1 per 1,000 live births, was recorded in 1956.

The mortality incidental to childbearing likewise set a new low record. There were only about three deaths for every 10,000 live births in 1960, or appreciably less than half the rate recorded only a decade earlier.

"The continued decline in the death rate from tuberculosis is another favorable aspect of the health record," the statisticians point out. "It appears that the mortality from this disease in our country will be about six per 100,000 population." Poliomyelitis cases fell sharply. About 3,200 cases of the disease were reported in the United States during 1960, compared with 8,425 in 1959.—*JAMA*, Jan. 21, 1961.



Is a Layman Your 'Consultant,' Doctor?

THE PRACTICE OF PATHOLOGY and operation of a clinical laboratory is the practice of medicine. This fact has been repeatedly reaffirmed by the American Medical Association and its constituent societies. Laboratory examinations, whether performed in hospital laboratories or in laboratories outside of the hospital, are consultations, as they have diagnostic or therapeutic implications on patients. Practicing pathologists, like other physicians, are licensed to practice the healing arts. Being specially trained in the fields of anatomy, physiology, biochemistry, microbiology, serology, hematology and clinical medicine, they are especially qualified as consultants in the choice and interpretation of clinical laboratory procedures. As partners in the practice of medicine, the pathologists must meet high professional and ethical standards. Their code of ethics and that of their medical technologists-assistants assures protection of your patient. Medical ethics evolved only to serve the best interest of the patient.

New 'So-Called' Laboratories

In spite of all these facts, recent years have witnessed a mushrooming of so-called "medical laboratories" often conducted by poorly qualified laymen not bound by medical ethics and infringing on the practice of medicine. Some of these laboratories are engaged in extensive advertising offering services on a flat contract fee basis or

"cut-rate" prices. The sorry state of some such laboratories in New York City was recently disclosed by an official investigation and given publication in many news media under such titles as "Larceny in the Labs" (*Time*), "The Deadly Mistake" (*Newsweek*), etc. Prothrombin tests were performed with a broken stopwatch, coagulation times were determined on blood collected in oxalate tubes, sedimentation rates were carried out in samples collected as far away as Los Angeles. Such laboratories could not exist if not supported by members of the medical profession.

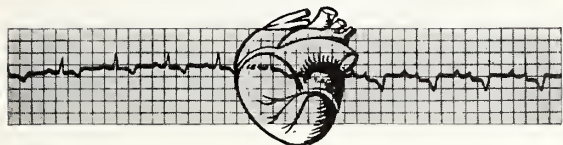
John Ruskin once said:

"There is hardly anything in the world that someone cannot make a little worse and sell a little cheaper—and the people who consider price alone are this man's lawful prey."

Doctor, can you afford "cut-rate" results in your medical care? Do laboratory consultations from a layman serve you as well as those from a physician? You want to give the best care to your patient. Why not demand the best in laboratory work and protect your patient?

The Indiana Association of Pathologists urges you to consider the professional and ethical qualifications of those to whom you refer your patients or specimens for laboratory work. Let's keep the entire medical care—and that includes all pathology services—in the hands of those best qualified to administer it: the physicians. ◀

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Value of Anterior Chest Leads in the Diagnosis of Diaphragmatic and Posterior Myocardial Infarction

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Indianapolis

THE PURPOSE of this month's cardiogram study is to point out the confirmatory value of anterior chest leads in the diagnosis of posterior and/or diaphragmatic myocardial infarction, a fact that has not received due consideration. Changes due to infarction of the diaphragmatic portion of the heart (commonly and erroneously called posterior) are referred to leads having the left leg as one of the lead connections (Limb leads II, III and AVF), where the diagnostic QRS, ST and T wave alterations appear. In a true and pure posterior infarction, on the other hand, the "infarction" forces (vectors), being directed away from the site of the lesion, point anteriorly. This admittedly rare type of infarction fails to register in the extremity leads (frontal plane) and the only clue as to its existence may be an increased QRS voltage in the right precordial leads (V_1 - V_3), the latter reflecting the unopposed anteriorly directed "infarction" force.

Case Illustrations

Figure 1 illustrates unequivocal evidence of myocardial infarction and is reproduced pri-

marily to demonstrate the genesis of increased QRS amplitude in right ventricular leads.

G.H. 404186 shows evidence of diaphragmatic (changes in II, III, AVF)—apical (changes in I, V_6) infarction. As one would expect the infarction force, being directed away from the site of lesion, is oriented to the right and anteriorly, giving rise to an R wave in AVR and RS in V_1 , V_2 .

C.M. 404051 also shows evidence of postero (II, III, AVF)—apical and perhaps lateral (V_5 , V_6) infarction, with "infarction" vector oriented anteriorly and giving rise to high amplitude R in V_1 and V_2 . Superficially both tracings may be confused with cor pulmonale.

Figure 2 was obtained six months after occurrence of an acute diaphragmatic myocardial infarction and demonstrates the value of V_1 lead as confirmatory evidence of infarction. Standard lead II shows a small initial Q wave, but leads III and AVF have a small positive initial deflection (initial 0.01 second vector), a fact which might make one hesitant to diagnose an infarction with any degree of certainty. The fact of the matter, however, is that an infarction sparing the septum does not interfere with the early order of depolarization. Initial septal force (vector) located at an angle of -135 to ± 180

* Supported by the Herman C. Krannert Fund of the Indiana Heart Association, Indiana State Board of Health and the National Heart Institute (H.T.S. 5363).

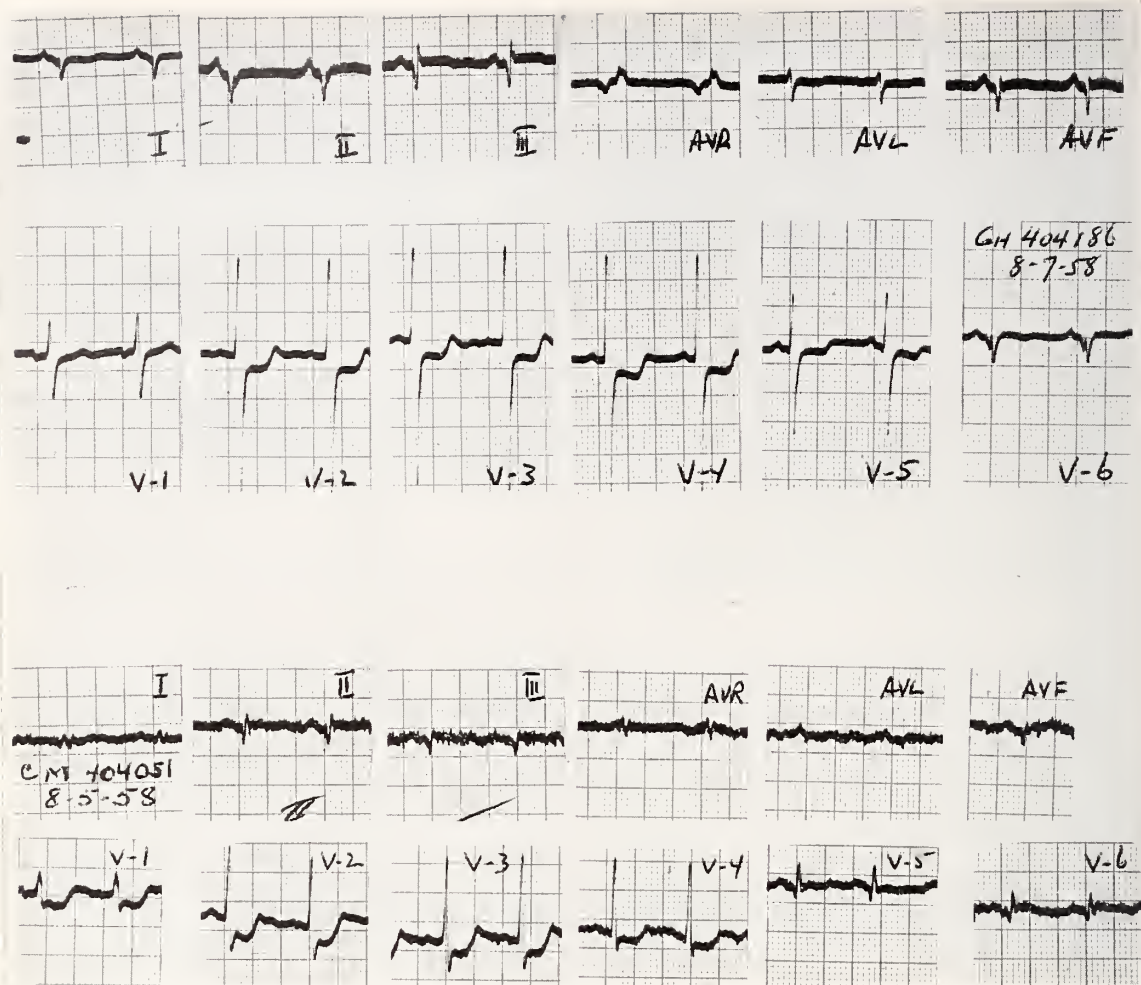


FIGURE 1

THE VALUE of V_1 in confirming the existence of posterior or diaphragmatic infarction when the limb leads are equivocal.

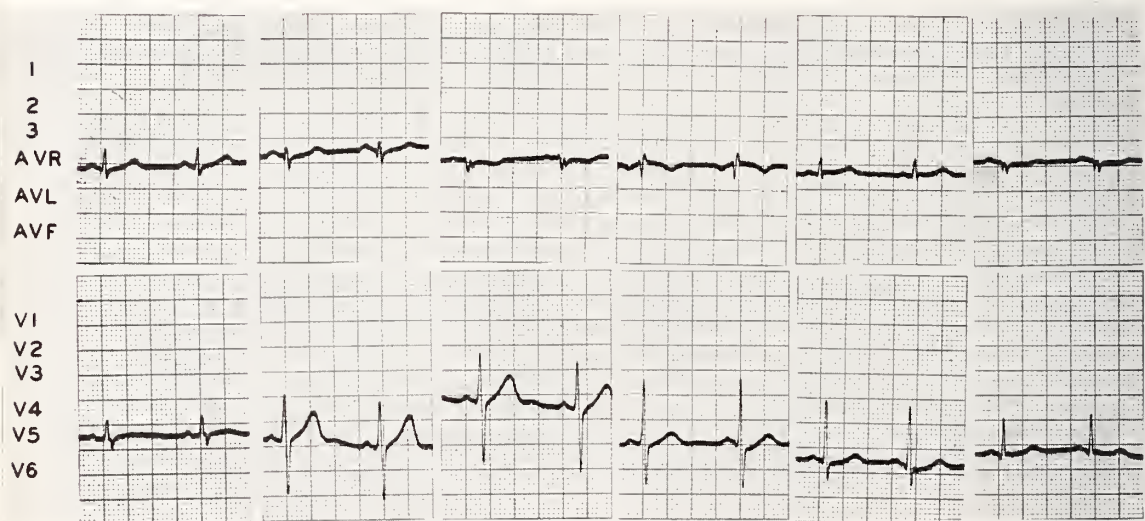


FIGURE 2

TWO CASES of myocardial infarction with infarction vector oriented anteriorly in C.M. 404051, and anteriorly and to the right in G.H. 404186 resulting in a tall R in right precordial leads (V_1 - V_3).

would give rise to initial QRS deflections similar to those observed in our case, in spite of the presence of a posterior myocardial infarction.

In this instance the existence of infarction is confirmed by the tall R in V_1 which appeared during evolution of the infarction. ◀

The Journal of the
Indiana State Medical Association
MEDICAL ESSAY CONTEST
for
Interns and Residents of Indiana Hospitals

During the intern and resident year of 1960-61 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of \$100.00, a second prize of \$75.00 and a third prize of \$50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1961.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Woggener, 1021 Hume Mansur Bldg., Indianapolis 4.

LABORATORY MEDICINE

Published periodically as a review of clinical laboratory procedures suitable for laboratories with minimal equipment.

Urinary Chloride (Fantus Method)

A. WENDELL MUSSER, M.D.*

Indianapolis

OUR KNOWLEDGE of serum electrolytes and acid base balance has increased greatly in the past few years. Intricacies of the basic mechanisms have become clearer to us with the advent of more exact analytical methods and instrumentation. These procedures and their interpretation are best handled by specially trained individuals. A great deal of information, however, concerning electrolyte balance can be obtained from many simple, roughly analytical procedures. One of these is the urinary chloride determination—the Fantus method.

Abnormalities in the excretion of urinary chloride occur in many disease processes. In severe, untreated diabetes insipidus, the concentrations of sodium and chloride in the urine are very low, primarily because of large water output. Daily excretion of the elements, however, is usually not abnormal. Administration of large quantities of sodium chloride does not result in the excretion of a concentrated urine as one would expect, but rather in an increased amount of dilute urine. On occasion if water is restricted at the same time as the sodium chloride is given, there is an increase in the excretion of sodium chloride.

Urinary sodium and chloride usually decrease when they are lost in abnormally large amounts via other channels; such as vomiting, diarrhea, excessive sweating and loss of gastrointestinal secretions by any means. Conversely, in "renal tubular acidosis," large amounts of sodium, chloride and potassium are lost in the urine as a result of inadequate reabsorption caused by a defect in the mechanism for acidification of the urine. Use of mercurial diuretics also increases the urinary sodium and chloride. Urinary sodium, chloride and potassium are increased in periods of diuresis and increasing acidosis and dehydration in diabetes mellitus. Addison's disease results in loss of sodium, chloride and water in the urine.

Excretion of chloride in the urine diminishes sharply during the course of pneumococcal pneumonia and other infectious diseases accompanied by hypochloremia. In the first 24 to 48 hours following major operations, the urinary sodium and chloride, as well as the urinary volume, tend to decrease.

Method

Place 10 drops of urine in a test tube. Add one drop of 20% aqueous potassium chromate solution. Rinse dropper in distilled water. With the same dropper, add 2.9% aqueous silver

* From the Clinical Laboratory, Indiana University Medical Center.

nitrate solution a drop at a time, while shaking the tube, until the contents suddenly change from yellow to red-brown. Count the number of drops.

The number of drops of silver nitrate required to produce the color change equals the urine sodium chloride concentration in grams/liter. Normal finding is 10-15 grams sodium chloride/24 hr.

This is predominantly a bedside or office procedure. It is accurate only to 0.5 gm sodium chloride/liter. The urine is titrated with silver nitrate and the chloride precipitated as silver chloride. The endpoint is indicated by the forma-

tion of red silver chromate when the first excess of silver is added. Periodically a blank should be run using distilled water to detect contamination of reagents with chloride.

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1. Weisberg, H. F.: *Water, Electrolyte and Acid-Base Balance*. The Williams and Wilkins Co., Baltimore, 1953.
2. Overman, R. R.: Sodium, Potassium and Chloride Alteration in Disease. *Physiol. Rev.* 31:285-311, 1951.
3. Selkurt, E.: Sodium Excretion by the Mammalian Kidney. *Physiol. Rev.* 34:287-333, 1954.
4. Fantus, Bernard: Fluid Postoperatively. *J.A.M.A.* 107:14-17, 1936. ◀

New Pathology Forum

The Pathology Information Committee of the Indiana Association of Pathologists will conduct a "question and answer" column in the Pathfinder section of The Journal. Queries in the fields of anatomic or clinical pathology may be addressed to The Journal, 1019 Hume Mansur Bldg., Indianapolis 4. Answers and discussions will be published periodically.

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The anti-inflammatory and antipruritic efficacy of triamcinolone acetonide was shown by the prompt control of itching and resolution of affected areas. Cahn, M. M., and Levy, E. J.: A Comparison of Topical Corticosteroids: Triamcinolone Acetonide, Prednisolone, Fluorometholone, and Hydrocortisone.

Antibiotic Med. & Clin. Ther. 6:734 [Dec.] 1959.

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Indiana Hospital Usage Compared

INDIANA BLUE CROSS was in the health insurance news again recently. The Health Information Foundation utilized a hospital cost report* to compare hospital usage in Indiana with hospital usage in the Province of Saskatchewan, Canada.

Local statistics were taken from the records of 843,000 Blue Cross subscribers in 1956. The Canadian experience was for 1957 and covered 827,000 persons, approximately 94% of the estimated population.

Since the two populations differ considerably in age and sex factors, the Saskatchewan data were adjusted to provide results which could be compared with those of Indiana.

Gross results were much higher in Canada, but even after adjustment the difference is remarkable. Admissions per 1,000 population were 115.5 for Indiana; the adjusted rate for Saskatchewan was 202.0. Similarly, the average length of hospital stay was 7.3 days in Indiana, 8.7 in Canada. Annual hospital days per 1,000 population stood at 838.8 for Indiana and a huge 1,753.7 for Saskatchewan.

Admission rates, length of stay and total days in one year were calculated for individual diseases and for several age brackets. In each instance the Canadian rates were substantially above similar rates in Indiana.

Analysis showed that the figures in Saskatchewan, after adjustment for differences in age and sex distribution, were higher than in Indiana because of greater use of hospitals in Saskatchewan for obstetrical care and respiratory diseases. Birth rates in the Canadian province are slightly higher than in Indiana, but the hospitalization utilized for obstetrical patients is proportionately much higher. In addition, hospital use in Saskatchewan was higher for nearly all major diagnostic categories.

Health Information Foundation meticulously avoids any judgment as to which rate of use is correct, and in fact does not intimate that either rate is correct or incorrect. The Foundation's conclusion is that a wide range of acceptable utilization rates exists in different situations.

Basic differences between the two hospitalization plans were that in Saskatchewan there is no limit on the hospital care a beneficiary may receive as long as the doctor considers hospitaliza-

*"Costs of Hospital Care in Indiana 1956," by Harry Hineman, Blue Cross Hospital Service, Indianapolis.

tion necessary, and no benefits are withheld because of age or pre-existing conditions. Neither plan admits patients for purely diagnostic services.

The Saskatchewan Hospital Services Plan covers hospitalization of residents on an insurance basis through prior payment of a "hospitalization tax."

'Scientists of Tomorrow'

SCIENTISTS OF TOMORROW this year is sponsoring its sixth annual round of science seminars for high school students. DePauw University will be the host for such a program from June 25 to July 8. Numerous other seminars will be held during the summer vacation on a regional basis throughout the United States. Students from seven states are being invited to the DePauw meeting.

Scientists of Tomorrow is a non-profit organization. It sponsors the seminars under the title of Junior Engineers' and Scientists' Summer Institutes (JESSI) for the purpose of providing guidance to high school students in regard to careers in science and engineering and related professions. JESSI is described as a two-week exploration in the pure and basic applied science field of learning. The subjects explored include physical sciences, engineering, biological sciences, the medical profession and pharmacy.

The institute is designed to help answer for high school students their questions as to whether they are interested in the sciences and engineering, whether they want to pursue such careers, whether they are equal to the academic work

required and what they can do in the remainder of their high school course to prepare for college studies.

JESSI students are selected from the junior and senior classes of high schools. Each student must have completed a specified number of science courses, but need not be especially interested in science or engineering. Many attend the sessions, without any leaning for their life work, and solely to obtain information. No attempt is made to pressure the enrollees into a science career.

During the first three years 1000 students attended. In 1959 there were 552 enrollees and in 1960 there were 677. In the past two years 57 students have attended from Indiana.

A great variety of public-spirited organizations have sponsored applicants in the past and Scientists of Tomorrow is inviting more widespread participation. Several medical societies over the country and at least one county medical society in Indiana have assisted worthy students. Full details may be obtained by writing Scientists of Tomorrow at 309 New Fliedner Building, Portland 5, Oregon.

Exfoliative Cytopathology of Uterine Cancer

THE TIME IS HERE for an all-out "smear campaign" against uterine cancer. We must expend every effort to eradicate this oncedreaded enemy. The means are at hand. We must simply organize their utilization.

Cytologic diagnosis of cancer of the female sex organs is based on the microscopic examination of smears prepared from the fluid content of the vagina, the cervical canal and the endometrial cavity. Mucous membranes of these organs, because of their exposure to extraneous factors, are subjected to an extensive shedding of their superficially-located cells. "Exfoliative cytopathology" is the term coined to specify this investigative technic. Fortunately, carcinomas arise from the lining mucous membranes and

shed their abnormal cells years before the lesions become grossly manifest. There is mounting evidence that pre-invasive carcinoma of the cervix, detectable by cytologic examination, is present for approximately eight to 10 years before the appearance of invasive carcinoma. Furthermore, invasive carcinoma may be present for several years before the patient experiences symptoms. By this time the lesion may be incurable. On the other hand pre-invasive carcinoma of the cervix is practically always curable.

The census indicates that there are over 33,000,000 women between the ages of 35 and 70 years in this country. It has been conservatively estimated over 200,000 of these harbor pre-invasive carcinomas of their cervix at the

present time. An additional 35,000 women have early invasive carcinomas which are grossly not apparent. The constant development of additional lesions must also be considered.

Diagnosis of all such cases is only possible through routine screening of apparently normal women by exfoliative cytology. This procedure is simple, accurate and inexpensive. The technic for obtaining the specimen requires no special training. Following simple directions available from numerous sources is sufficient. Specimens can be prepared and screened by technicians with a basic knowledge of histology and special training in exfoliative cytology. Final interpretation of abnormal morphology, however, requires considerable training and experience.

A good understanding between the clinician and the cytopathologist on the formulation, classification and interpretation of cytologic reports is of paramount importance. In addition to obvious diagnoses there are a number of conditions which are considered pre-malignant or potenti-

ally malignant. The management of these lesions is best obtained by direct consultation with your local pathologist.

Recent figures indicate that the facilities and utilization of this important case-finding technic are sadly lagging in the state of Indiana. It is necessary for physicians acting as individuals or as societies to cooperate with the members of the Indiana Association of Pathologists to initiate or expand the utilization of this procedure. Specific aid in programs of evaluation and development can also be obtained from the state and county units of the American Cancer Society.

In summary, exfoliative cytopathology is a practical method for the detection of uterine malignancy in the curable stage. Every woman that visits a doctor's office deserves the benefit of this procedure. Death by cancer of the uterus can be virtually "smeared" from the rolls of vital statistics. The responsibility of meeting this goal rests with every physician in this state.—Anthony Pizzo, M.D., Bloomington.

More Self-Policing or More FDA?

A SPECIAL COMMITTEE looking into the operations of the Food and Drug Administration has suggested that "the FDA be given authority to require manufacturers to show proof of the *efficacy*, as well as the *safety*, of all new drugs" (Tighter Controls Suggested for FDA, *MHVN*, Nov. 4).

This was once, of course, the prerogative and responsibility of the Council on Pharmacy and Chemistry of the American Medical Association. By virtue of its independent laboratory for verifying the claims made by manufacturers, U. S. physicians—and through them the people—had an independent body which obtained its influence simply by publication of its investigations and opinions. Through the power that rested in the control of advertising of new drugs, the Council was able to secure the complete cooperation of leading pharmaceutical manufacturers in maintaining high standards of production, advertising and distribution. This was a great service to the medical profession and the public, and the results were appreciated throughout the world.

Government Moves In

With the passage of the New Drug Act in the late 1930's, however, Government agencies were given greater authority and greater responsibility in certifying new drugs. Advertising was regulated by the Federal Trade Commission, though the Council on Pharmacy and Chemistry was able to control to some extent the types of names for new products and for various brands of new products.

For a while the seal of acceptance of the Council had much influence. In more recent years the Council on Pharmacy and Chemistry—now renamed the Council on Drugs—has lost in strength, in influence and, indeed, in potency. The AMA Board of Trustees eventually removed the use of seals for all of the councils, emasculating still further the strength of its reports and its decisions. Today, the Council on Drugs publishes monographs on new or previously unevaluated drugs, occasional supplemental statements on the drugs already described and special reports on various therapeutic subjects.

In its last annual report the Council itself called attention to the apparent neglect of its statements by readers of the *AMA Journal* and was greatly concerned with trying to secure greater popularity for its book *New and Non-official Drugs*. Rumors are rife as to actions taken by various local and state medical organizations endeavoring to restore the Council to some of its former prestige and efficiency.

In a recent book, *The Health Hucksters*, a former employee of the National Better Business Bureau does an "exposé" of the pharmaceutical and drug field and urges that a special assistant to the President be hired who would advise consumers as to what is good and bad in this area.

The unfortunate result of much of the current

agitation by such groups as the Kefauver committee and others who have climbed eagerly on this bandwagon has been demands for restrictive legislation and requests for the Government to take over more and more of the regulations that were once the province of private enterprise. Certainly the world leadership now held by the American pharmaceutical industry is dependent on the initiative and energy that come with a free-enterprise form of government. Perhaps the Pharmaceutical Manufacturers Association or a similar group in the profession may be able to develop a competent body for self-regulation along the lines of the former Council on Pharmacy and Chemistry and thus avoid the current agitation.—Morris Fishbein, M.D., *Medical World News*.

Editorial Notes . . .

One of America's most serious public health problems, compulsory retirement, is decreasing. At least partly as a result of AMA recommendations, industries are remodeling their retirement policies and are tending away from forced retirement at age 65. AMA Past-president Dr. Louis Orr has repeatedly pointed out the dangers of retirement for individuals who are still in good health and capable of productive work. The number of people at age 65 and above in good health is increasing each year. Most of them would be happier at work even if they did not live as long as they would in idleness, but as a matter of fact busy people live longer and are happier too. Less retirement will produce longer lives, more happiness and more sanity.

Medical information will be transmitted electronically from the manned orbital capsules of Project Mercury. The spaceman's pulse, temperature, respiration, physical reactions and oxygen consumption will be relayed to ground stations. In addition to medical data the transmission will include many items of the capsule's function. About 90 different measurements will be required to keep the ground crew adequately informed. Receiving stations are being erected throughout the world. Each of these will in turn transmit the data to a central installation in Maryland.

Possible loss of foreign doctors who fill hospital training positions is a minor element in the problem of unfilled internships and residencies, according to Dr. Willard Rappelye, former dean of Columbia University College of Physicians and Surgeons, and now president of the Josiah Macy, Jr. Foundation. Approximately 12,000 foreign graduates now occupy 33% of the house staff positions in this country. A considerable number of this group might leave due to failure to pass the qualifying examinations, but would not affect the situation very much in a proportional way due to the fact that there are 13,032 approved internships and 30,733 approved residencies.

There were 7,081 new graduates of American schools in 1960. There are either too few graduates or too many internships and residencies. Number of graduates will increase slowly, but there is no expectancy of solving the problem solely in this way.

Dr. Rappelye recommends dropping the internships and residencies in which the service functions predominate over the educational elements. He also recommends that hospital staffs requiring house officers and finding it difficult to attract them with truly educational opportunities solve the problem by hiring well-trained young doctors and pay them adequate salaries for a period of a few years while they are establishing themselves for private practice.

The United States Civil Service Commission has announced that the provisions of the Retired Federal Employees Health Benefits Act will become effective July 1, 1961. Eligible retired Federal employees or their survivor annuitants who desire to participate in the program may enroll in a Uniform Plan which is being established by a contract with the Aetna Life Insurance Company. Three types of coverage are offered: basic coverage only, major medical coverage only, or a combination of both. The government contributes \$3.00 a month for an individual and \$6.00 per month for a family to any of the three types of coverage.

The incidence of heart attacks was studied amongst employees of du Pont Company and reported in an article by Drs. Pell and D'Alonzo in the J.A.M.A. recently. Male workers were divided into five groups on basis of salary and job responsibility. Heart attacks were fewest in the highest salary group, two per 1000 per year. The next highest salary group had a rate of 2.4. The rate was 3.8 and 4 in the two lower-salaried groups. The fifth group were production workers who were more physically active than the men in the other four

groups. The rate for the physically active was 2.9 per 1000 per year. One of the authors' conclusions was that if job stress was a factor in heart disease the lower-salaried group must be under more stress as a result of their efforts to attain the upper brackets.

Changes in state and regional population figures due to migration were tallied recently by the Metropolitan Life Insurance Company. Americans are a mobile race—during the 1950's approximately one-fifth of the population changed residence each year. Shifts from one state to another were mostly in favor of the Pacific Coast, the Southwest and Florida. Gains in these areas for the decade just closed were in the order of 30%. California, for instance, gained by migration by over 300,000 persons each year during the the 1950's; 28 states and the District of Columbia saw more people moving out than moving in. The South, the Midwest and the Northeast regions were the favorite places to leave. The Northeast more than offset its losses, however, by immigration from Europe and Puerto Rico. Indiana gained by migration by four percent in the 1940's and by 2.2 percent in the 1950's.

About Our Cover

Each year brings new knowledge and technics to lift the veil which conceals the cause of that mysterious and malignant disease, cancer.

Thanks to scientific advances making early detection possible, hundreds of those stricken can now be cured and live their lives to the full—saved from what would once have been a death sentence with no hope of appeal.

Soon, we universally hope, the day must dawn when prevention will become an accomplished fact and the necessity for radical surgery to cure, or, in many cases to unfortunately only halt the march of malignancy toward its inevitable conclusion, will become a memory of the past.

This month's cover, created for us by an Hungarian artist, Laszlo Balogh, Indianapolis, symbolizes medicine's unceasing struggle to conquer this crippling scourge for all mankind.—M.E.F.

“nutrition...present as a modifying or complicating factor in nearly every illness or disease state”¹

1. Youmans, J. B.: *Am. J. Med.* 25:659 (Nov.) 1958

cardiac diseases “Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease.”²

2. Kampmeier, R. H.: *Am. J. Med.* 25:662 (Nov.) 1958.

arthritis “It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . .”³

3. Fernandez-Herlihy, L: *Lahey Clinic Bull.* 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.⁴ Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.⁵

4. Sebrell, W. H.: *Am. J. Med.* 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: *Therapeutic Nutrition*. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases “Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult.”⁶

6. Overholser, W., and Fong, T. C. C. in Stieglitz, E. J.: *Geriatric Medicine*, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.⁷

7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: *Medical Science* 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.⁸ “Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes.”⁹

8. Duncan G. G.: *Diseases of Metabolism* 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: *Am. J. Med.* 25:708 (Nov.) 1958.

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Needle Points—Improved Means of Sharpening

RALPH U. LESER, M.D.

Indianapolis

DURING THE 1920's, Dr. John H. Stokes wrote in *Modern Clinical Syphilology*, "The needle is a surgical instrument, although its long association with the tailoring trade and the pin cushion in our minds has perhaps not been the best way to impress us with the fact.

"Inspection of a needle with seven-diameter lens will sometimes reveal the source of the personal unpopularity of an operator with his patients. In luxurious practices it may be possible to forestall some trouble by using a new needle at every injection, but in the coming era of economy many will be obliged to point their own needles, if not to cobble their own shoes. Needles do not retain point or edge indefinitely, although the fact is easily forgotten. In fact, it is well to retouch a needle to the proper edge and point with each five to 10 punctures."

A glance at many a needle selected at random in a hospital or in a doctor's office and placed under a magnifying lens, or under the low power objective of a microscope, reveals the fact that Dr. Stokes' picturesque and trenchant advice has frequently been disregarded. Most doctors, nurses and technicians have not inspected needles under magnification. Often the only criteria of acceptability are patency of the lumen and the absence of the "hook" or "burr" (Figure 1, D & E), demonstrated by passing the needle point through cotton or simply by running it over the finger. These maneuvers have some value but fail to identify the "chisel" type of needle (Figure 1, B & C).

Some regard the patients' complaints concerning pain of venipunctures or of subcutaneous or

intramuscular injections as manifestations of hypersensitiveness or querulousness. The results: continued use of dull or hooked needles with missed or mutilated veins, hematomata, infiltrations, inadequate blood samples, bilateral frayed nerves and damaged rapport. The growing economic importance of the problem is indicated by Tovell, stating that "at Hartford Hospital, over 60,000 needles have been procured in the last three years. During that period, demands placed upon the purchasing agent have increased by 50%, to the point where one needle is required per bed approximately every 10 days."

Suggested Remedies

1. Replacement of needles by new ones with every five to 10 punctures, in plush practices. Disposable needles are available, but their use is prohibitive for most because of the expense.
2. Frequent inspection of needles, not only with the aid of finger and cotton, but with a magnifying lens, preferably that of a microscope.
3. Sharpening of defective needles, employing the lens to determine if the honing has been effective.
 - a. The least expensive way to secure the pointed tip is to hone the needle with the aid of a whetstone.
 - b. Electrically driven whetstones are commercially available and are in use in some hospitals and doctors' offices.
 - c. Franz and Tovell designed a sharpener which is commercially available in two

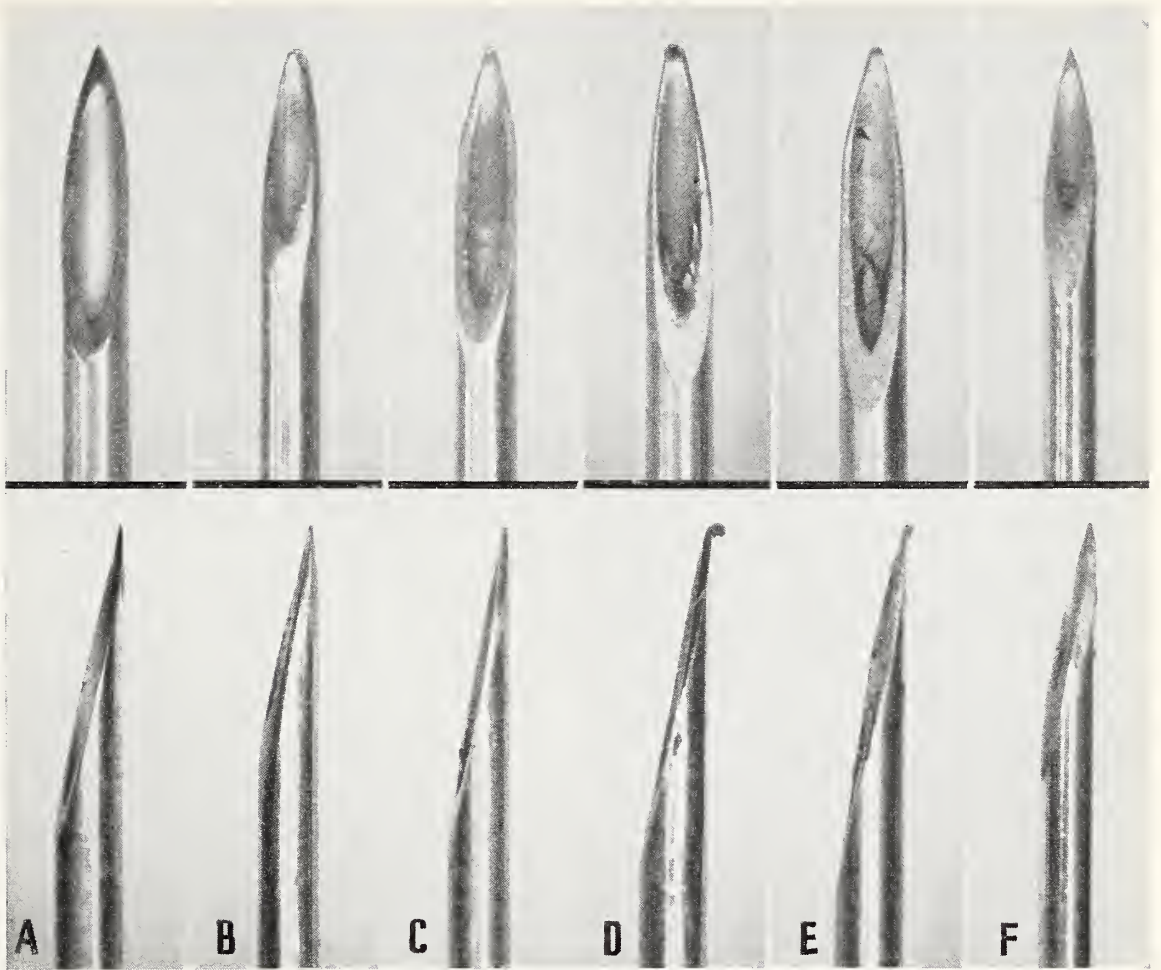


FIGURE 1

NEEDLES DEPICTED in the top row are directly above their respective profile views in the bottom row. A. New needle. B. Needle of "chisel" type. C. Another chisel type, less pronounced. D. "Hook" or "burr"-type needle point. E. The "hook" type, less pronounced. F. Sharpened needle.

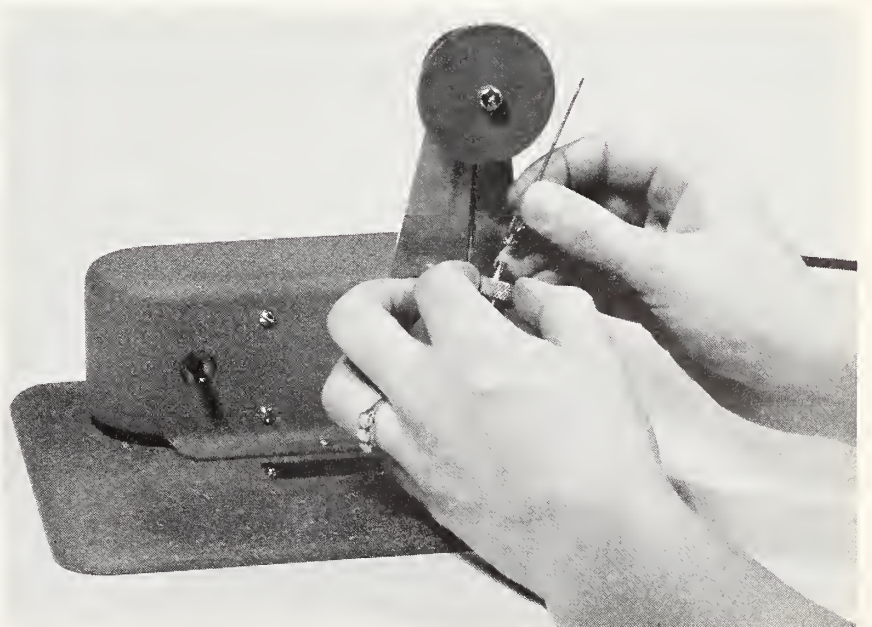


FIGURE 2

THE FRANZ AND TOVELL Sharpener, showing grinding wheel, needle on chuck and housing for mechanism. The instrument is manufactured by the Frons Mfg. Co., Inc., New Haven, Conn.



**DORNWAL® IS THE TRANQUILIZER
VERSATILE ENOUGH TO
BE USED ALMOST ANYWHERE.**

Take, for instance, the woman in our picture, suffering from a really severe tension headache. Aspirin she has tried, of course; but suppose she's called you and you prescribed Dornwal. What would you expect?

First, let us say you told the druggist to indicate the dosage that our clinical research has shown is useful in these cases — 1 or 2 tablets t.i.d. In all probability, she would experience relief of pain and a general relaxation in less than an hour. If she is doing her housework, she could go on with it, because she wouldn't get sleepy.

Dornwal is one tranquilizer that doesn't make people sleepy. It's a tranquilizer pure and simple. Its effectiveness you will see clearly the next time you encounter a patient given to tension headaches. Try Dornwal and see the results.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

Maltbie Laboratories Division,
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PDW-11

NEEDLE POINTS

Continued

models, one hand-operated and one an electrically driven device (Figure 2).

Needles one-half an inch to two inches in length, as well as hypodermic needles, can be sharpened. Both the needle and the grinding wheel rotate, and the machine is designed so that as the needle rotates, it lifts away from the wheel in order to preserve the cutting edges of the bevel. A convex bevel is produced and hooks curled backwards from the beveled surface are ground away. This sharpener produces sharp points, keen cutting edges and a bevel which is resistant to hooking. Needles are more likely to be sharpened because placing the needles on the chuck, turning on an electric switch, sharpening a number of needles and turning off the switch is far less laborious and much speedier than other methods of sharpening.

Conclusions

1. A glance at "A" and "F" of Figure 1 indicates that a sharpened needle can closely resemble a new one.

2. The obvious admonition is for exertion of greater diligence in eliminating faulty needles.

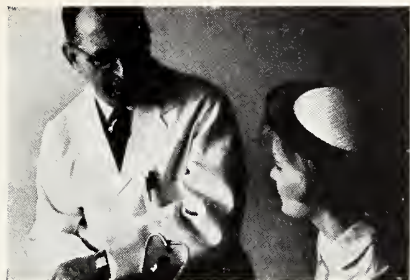
3. The various means of sharpening needles have been described, the best of which is use of a new electrical sharpener devised by Franz and Tovell.

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2. Franz, Frederick, Tovell, Ralph M.: A Study of Hypodermic Needle Points. *Anaesthesiology* 17:724 (Sept.-Oct.) 1956.



"I think the doctor analyzed my case quite correctly . . . he said I had the housemaid's knee!"



SUCCESSFUL FAMILY PLANNING...BASED ON YOUR COUNSEL AND **LANESTA® GEL**

Every young couple about to be married needs advice of all sorts, and they'll get it, too — from everybody — some good, some bad. But some of the most valuable counsel they can get — help in planning their own family — comes best from you. Their family happiness for many years can depend on what you suggest to them, including your recommendation for the use of Lanesta Gel.

Lanesta Gel, with or without a diaphragm, is a most effective means of conception control. Lanesta Gel offers faster spermicidal action because it rapidly diffuses into the seminal clot. In fact, Gamble ("Spermicidal Times of Commercial Contraceptive Materials — 1959"*) *found the mean diffusion spermicidal time of Lanesta Gel to be three to seven times faster than the mean diffusion times of ten leading commercially available contraceptive creams, gels, or jellies.*

Lanesta Gel has complete esthetic acceptance and is well tolerated. *Gamble, C. P.: Am. Pract. & Digest. Treat. 11:852 (Oct.) 1960.

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AMA Proposes Program to Ease Plight Of Foreign Physicians Failing Exams

The American Medical Association is standing fast on its policy relating to graduates of foreign medical schools, but is offering a proposed educational program that will ease the plight of nearly 2,500 foreign physicians who have failed to pass qualifying examinations and face deportation.

The AMA said it is standing by its policy because it believes graduates of foreign medical schools should meet the same minimum standards of education as graduates of U. S. medical schools as nearly as can be measured. These standards have been set up to insure patients in hospitals proper medical care.

The American Medical Association pointed out that American students graduating from foreign medical schools are required to pass this same examination before being permitted to continue their medical education in the United States as interns or residents which inevitably involve patient care.

Ask Development of Programs

Dr. Leland S. McKittrick, Boston, chairman of the AMA Council on Medical Education and Hospitals, said that through mutual agreement with the State Department in Washington, the American Medical Association, the American Hospital Association and the Association of American Medical Colleges, hospitals will be urged to develop a special educational program for this group of foreign graduates who failed. The program, however, will not involve patient care. The proposal calls for the program to be carried out until June 30, 1961. This will permit the U. S. Immigration and Naturalization Service to extend the educational exchange visas of these foreign doctors and enable them to take the Educational Council for Foreign Medical Graduates examination next April 4.

Details of the educational program, Dr. McKittrick said, will be worked out by each individual hospital in order to conform to the specific educational needs of the foreign doctors. Under such a proposal there will be no sudden forced

exodus of those who have failed previous examinations. After Dec. 31, hospitals face loss of approval of their intern and residency programs if the programs include foreign medical graduates who are not certified by ECFMG.

In the past, foreign physicians were granted visas to continue their education under the Smidt-Mundt Act. The U. S. Immigration and Naturalization Service issued the visas, working closely with the State Department in its educational and exchange program for foreign students. To qualify a foreign graduate had to be enrolled in an educational program approved by the State Department. The intern and residency program, whose educational standards were established by the AMA, was accepted by the State Department as meeting the requirements set forth in the educational exchange program authorized by Congress.

Hereafter, foreign doctors, who seek training as interns and residents in this country under the exchange program, must pass examinations in their own countries before coming to the United States. Only then will they be allowed to apply for a five-year exchange-visitor visa.

More than 70% of the foreign physicians who took the last ECFMG examination in September passed it. The total represented 5,306 out of 7,308. Dr. McKittrick said that 1,405 foreign doctors took the test in 66 centers outside the United States and 926 passed it.

"With hospitals facing loss of approval of their teaching programs after the Dec. 31 deadline," Dr. McKittrick said, "the immediate problem from the standpoint of everybody concerned is with the group of 2,481 foreign doctors who failed their examinations and face theoretical deportation."

Dr. McKittrick said that "there must be a balance of two basic concerns—for the American patient and for the foreign graduate."

"We must recognize the right of every patient in an American hospital to a quality of care which can be given only if every physician—regardless of origin—is fully qualified. But we

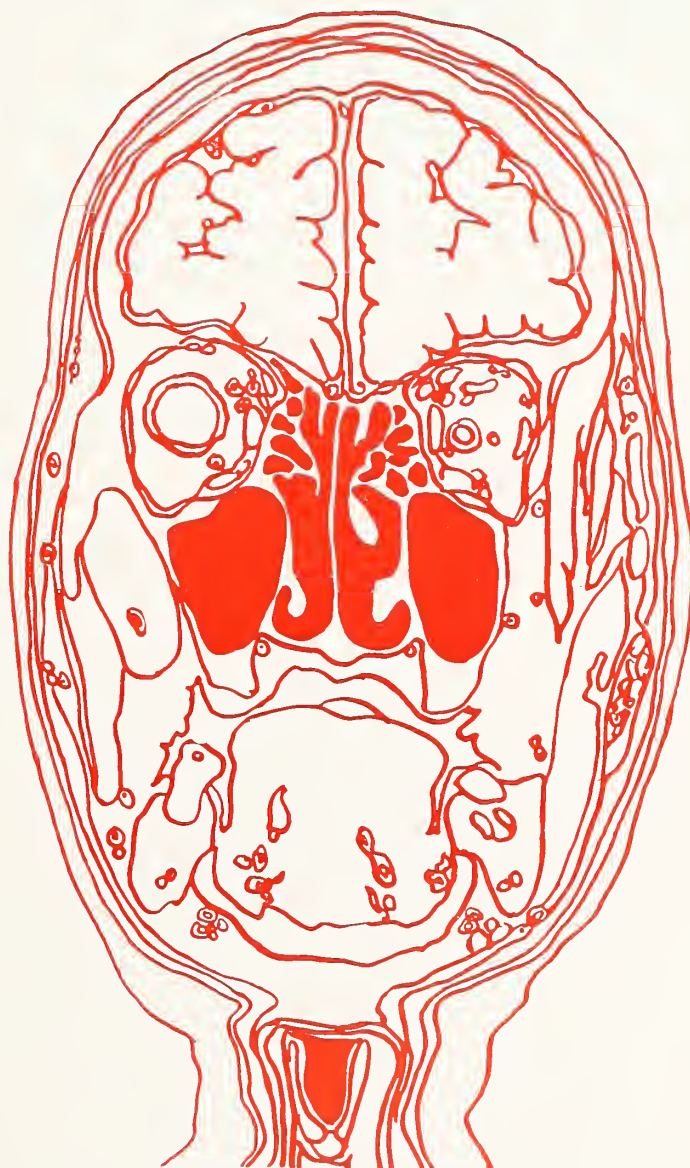
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GOVERNOR MATTHEW WELSH signs Senate Bill 221—an ISMA-backed measure which implements the Kerr-Mills Bill in Indiana, effective Jan. 1, 1962. Looking on are State Welfare Director Albert Kelly (left), and Dr. Guy Owsley, ISMA president.

AMA PROGRAM

Continued

must be equally interested in the impact of America on the foreign physician coming to these shores."

Standards Insure Quality Care

Dr. McKittrick said that the "high standards in intern and residency programs maintained by the AMA serve only one purpose: to insure the highest quality of medical care to all hospital patients."

Dr. McKittrick emphasized, therefore, that foreign graduates who have failed to pass the examinations conducted by the ECFMG will NOT be permitted to continue with their intern and residency program after Dec. 31, but we have been assured by the State Department that they will be permitted to remain in the United States until June 30, 1961, providing they are enrolled in an acceptable new program developed by the hospital. This program, Dr. McKittrick said, will have nothing to do with direct patient care, but will provide an opportunity for the foreign physician to continue his education and better prepare him for future examinations.

Dr. McKittrick said that hospitals which continue to accept foreign graduates, who failed in their ECFMG examinations, in their intern and residency program will run the risk of having their program disapproved. ◀

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VOLUNTEER REGISTERED nurses with teaching ability or experienced teachers are instructors of the Red Cross Core of the Sick and Injured course. In these classes, 32 simple nursing technics are taught, including how to give bed baths and how to prepare liquid and soft diets.

Many Red Cross Courses Are Service to Community

Individual, personalized, loving service in a familiar environment, the home, plays an important role in the recovery of a patient.

The Indianapolis Area Red Cross and several other Red Cross chapters throughout Indiana offer a Home Care of the Sick and Injured course to housewives, high school girls and other interested people.

This course has proven invaluable to the modern housewife not only in helping her make the best use of her time, energy and material but also in carrying out the doctor's orders, and applying the knowledge she has gained from the course in emergency situations.

The free Red Cross Care of the Sick and Injured course is taught by graduate nurses with teaching ability or persons with teaching experience. It consists of seven two-hour lessons. Thirty-two skills and technics are taught, including how to give bed baths, keep a record of the patient's temperature, pulse and respiration for the doctor, prepare liquid and soft diets, and how to improvise bed rests and houseslippers.

Importance in Disaster

Civil Defense authorities assert that in the event of a nuclear attack or accident in this country, our survival may very well depend on what everyone does for himself, one's family or neighbor during the first critical hours following such an attack or accident. Doctors and nurses in an emergency such as this would be unable to give the individual attention ordinarily given to their patients. One person trained as a home nurse could be of primary importance in

the recovery of injured or sick members of her family.

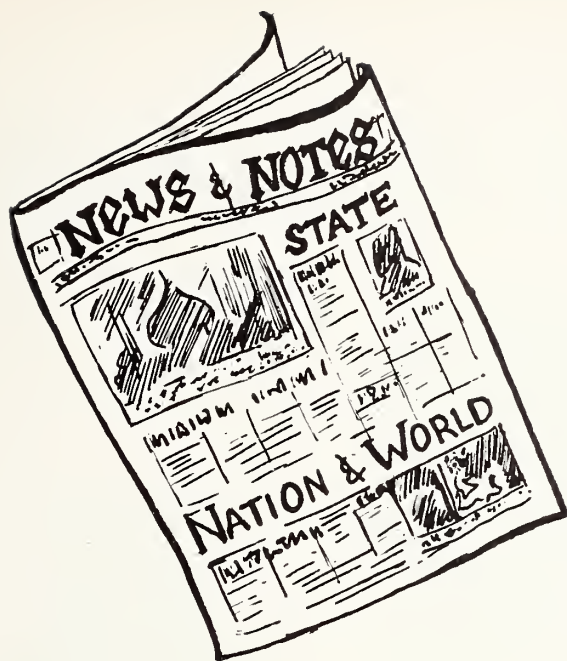
Another Red Cross course which has proven valuable to young married couples is Mother and Baby Care, taught by registered nurses who are Red Cross volunteers. This six-week two-hour course is recommended by many doctors in Indianapolis and is taught at Methodist and Community hospitals, and the Red Cross Chapter House.

The course stresses the baby's first year of life. It is open to expectant parents as well as any others who are interested. There are discussions and demonstrations on how to bathe, diaper, dress and feed the new baby properly. Members of the class learn about various baby bottles and sterilizers, and the baby's and the mother's diet. Necessary supplies and clothing are listed and discussed.

Other classes taught by Red Cross volunteers as a service to the community are: first aid, which enables a person to give on-the-spot assistance until the doctor arrives, and handicraft courses for instructors who in turn will teach classes for the blind, for youth groups and patients in veterans hospitals.

Two Red Cross services which have proven valuable in hospitals where they are available are the Red Cross Nurse's Aides, who have 40 hours of lectures and practical experience as their training, and the Gray Ladies who write letters, do shopping and perform other acts of kindness to cheer the patients.

Local Red Cross chapters may be contacted for further information on classes and services.



Editor to Become Chapter President At Indiana Surgeons Meeting

Dr. Frank B. Ramsey, Editor of the *Journal* and Associate Professor of Surgery at Indiana University School of Medicine, will be installed as president of the Indiana Chapter of the American College of Surgeons during its spring meeting, April 14-15, in Indianapolis.



FRANK B. RAMSEY, M.D.

A majority of the 300 Hoosier members of the chapter are expected in Indianapolis for the sessions, which combine scientific programs and a business meeting.

The scientific sessions, open to all interested physicians, will be at the Rice Auditorium, Indiana State Board of Health Building.

Dr. John Paul North, who recently succeeded Dr. Paul R. Hawley as Director of the American College of Surgeons, will speak at the Friday evening banquet on "The Future of the American College of Surgeons."

Dr. Ramsey, the new president, succeeds Dr. Mell Welborn of Evansville. Other chapter offi-

cers include Dr. David Bickel, South Bend, a *Journal* Editorial Board member, vice-president; and Dr. J. Stanley Battersby, Indianapolis, secretary-treasurer.

The meeting opens Apr. 14 with operative clinics at the I. U. Medical Center and V. A. Hospital. A special luncheon for the ladies is scheduled for noon at the Columbia Club. The banquet, at which Dr. North will speak, will follow a 6:30 reception at the Columbia Club.

Speakers for the two-day session will be Drs. Clyde Culbertson, Bruce Peck, John Tondra, Joseph Finneran, Fred Wilson, George Garceau, Richard Stander and Frank Vellios, all of Indianapolis.

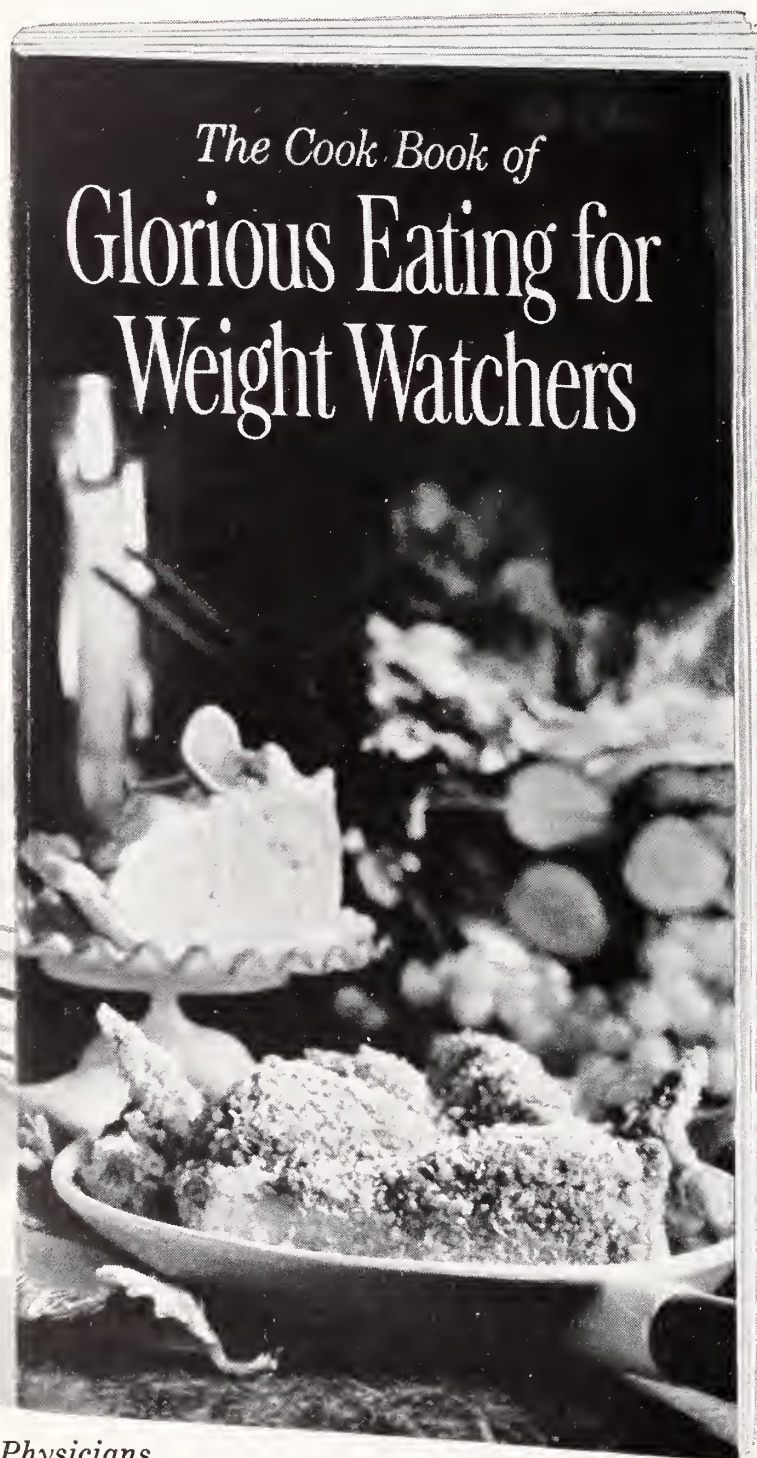
Also Drs. Robert Pickett, J. K. Berman, Thomas Johnson, Wayne Carson, Robert Garrett, John Russell, Harris Shumacker, Eugene Klatte, Donald Schlegel and Robert Lempke, all of Indianapolis, and Drs. Leo Radigan, Gary; Joe Jontz, Fort Wayne; Thomas Moore, Muncie; Joseph Davis, Marion, and Frank Scott, South Bend.

Dr. J. R. Matthew of North Judson has terminated his private practice and is now on the medical staff of Beatty Memorial Hospital.

Continued on page 542

A REALISTIC AID TO PROPER WEIGHT MAINTENANCE

At Last...New Cook Book Designed



Free to Physicians



Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

o Prevent Overweight Through Better Eating Habits

Recipes and Menus with Satiety and Appetite Appeal in Mind

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to *best* weights by sex, age, size and extent of activity.

Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way is not a crash program. It offers calorie controlled menus with appetite appeal, variety and satiety in mind. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Not a reducing manual. It should be explained that "The Cook Book of Glorious Eating for Weight Watchers" is a guide to the *prevention of obesity*. Its publication marks the first time

that a food manufacturer like Wesson has taken so important a step to help combat this serious public health problem.

Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.

Note: Please do not confuse this booklet with the *Cholesterol Depressant Diet Book*, published by Wesson as an aid to physicians and for professional distribution only. The concept of the *Cholesterol Depressant Diet Book* stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.



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Please send me my copy of "The Cook Book of Glorious Eating for Weight Watchers", plus two dozen order blanks for distribution to my patients.

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NEWS NOTES

Continued from page 539

South Bend Radiologist Elected Chancellor

Wallace D. Buchanan, M.D., South Bend, has been elected to a four-year term on the



W. D. BUCHANAN, M.D.

Board of Chancellors, governing body of the

American College of Radiology. Election took place during College's 37th annual meeting (Feb. 8-11) in Chicago. Dr. Buchanan received both his undergraduate and medical education at Indiana University, achieving

Indianapolis Native is Borden Award Winner

Dr. Robert F. Pitts, Professor and Chairman of the Department of Physiology, Cornell University Medical College, has been awarded the 1960 Borden Award by the Association of American Medical Colleges for his work on renal tubular functions.

Dr. Pitts is a native of Indianapolis. He received a B.S. degree from Butler University in 1929 and the M.D. degree from New York University College of Medicine in 1938.

NEW BOOKLET GIVES ADVICE TO CHILDLESS COUPLES

Advice to childless couples is contained in a recently published Public Affairs Pamphlet by Alan F. Guttmacher, M.D., and Joan Gould. It is entitled *Why Can't You Have a Baby?* (Pamphlet #309). It explains in lay language the conditions contributing to sterility and outlines diagnostic and therapeutic management. The pamphlet may be obtained by writing Public Affairs Committee, 22 E. 38th St., New York 16. Price is 25 cents per copy, with discounts for large orders.

Dr. George Plain, South Bend physician, spoke at a recent meeting of the Wisconsin Community Chests and United Funds in Racine, Wisc.

Former Hoosier Record Librarian Now With Pan American Bureau

Miss Carol Lewis, who received a B.S. degree in Medical Records from Indiana University in 1953, and who was Medical Record Librarian at the Larue D. Carter Memorial Hospital from 1953 to 1955, has been appointed as a specialist in Medical Records with the Pan American Sanitary Bureau. She will be stationed at the Buenos Aires Zone Office of the Bureau.

SECOND IN PAMPHLET SERIES DESCRIBES BIOLOGICAL, MEDICAL RESEARCH

The Atomic Energy Commission has published the second in a series of pamphlets describing its life sciences research program. The purpose is to acquaint scientists, students and interested members of the public with the bio-medical program, its objectives and needs. The Commission's bio-medical program is directed toward the accumulation of knowledge of the effects of nuclear radiation from any source—natural or man-made—upon living things.

The booklet, titled *Genetics Research*, was prepared under the direction of the Commission's Division of Biology and Medicine. It summarizes work in progress at 49 institutions through 101 research contracts or projects in the following major areas: (1) cytogenetics; (2) gene action; (3) genetics of populations—population dynamics and effects of mutations; (4) human genetics; (5) mammalian genetics; (6) microbial and biochemical genetics; (7) molecular radiation genetics; (8) mutation rate analysis, and (9) plant breeding and crop improvement.

The Commission's genetics program involves the study of genetic principles and mechanisms and the effects of radiation on these mechanisms, together with observations on the gross effects in populations or organisms. Projects in the areas mentioned above are intended to explore the mechanisms of radiation-induced genetic damage, the expression of this damage in individuals and populations and the mode and rate of elimination of the damage over many generations; to develop an understanding of the normal chemistry of genetic materials as prerequisite to understanding the way in which radiation acts upon these materials; to study therapeutic techniques for the prevention or



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with either Raudixin or Naturetin & K. *economy* — Maintenance dosage of only 1 or 2 tablets daily for most patients. *convenience* — Once-a-day maintenance dosage. Two potencies available.

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NEWS NOTES

Continued

reduction of potential radiation hazards to genetic materials.

The publication *Genetics Research* (TID-4041) is available from the Office of Technical Services, U. S. Department of Commerce, Washington 25, D. C., price per copy—\$1.25. The first pamphlet in this series—*Marine Sciences Research* (TID-4040)—may be purchased from OTS at 50 cents a copy.

I.U. 'Opportunity Day' Deemed Highly Successful

"Opportunity Day" at the Indiana University School of Medicine, during the holiday season, brought 134 students accepted for the 1961 beginning class, their wives and parents to the Medical Center campus in Indianapolis.

The highly successful program was developed by Dean John D. VanNuys and the faculty to give the students, wives and parents an opportunity to inspect teaching, study, and housing facilities, to meet members of the faculty and

staff and to participate in informal discussions on questions of finances, employment, student research and related topics. Tours of the Medical Science Building, research areas and the teaching hospitals were a part of the program.

The visitors were welcomed during a luncheon program by Dean VanNuys, Dr. J. O. Ritchey, admissions committee chairman, Dr. Guy Owsley, president of Indiana State Medical Association, and Dr. Donald J. White, president, Indiana University Medical Alumni.

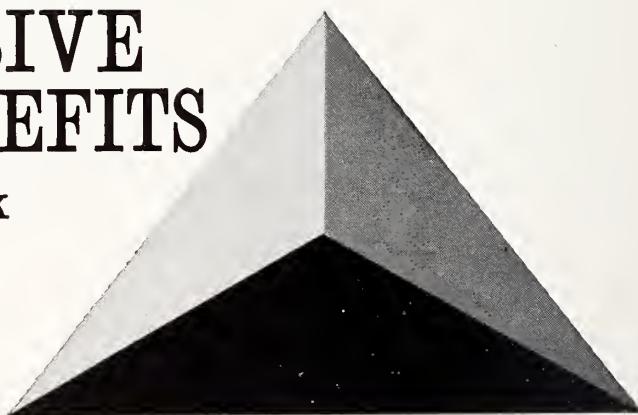
Mead Johnson Grant to Assist 10 Exiled Cuban Physicians

A grant of \$10,000 has been made by Mead Johnson Laboratories to the University of Miami School of Medicine to assist 10 exiled Cuban physicians in postgraduate study in Miami.

The Miami School of Medicine is providing lectures and tutorial sessions for 265 exiled Cuban physicians who are preparing to take the April examination of the Educational Council for Foreign Medical Graduates. Upon passing this examination, they will be eligible for positions in American hospitals and universities.

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50 mg. • L-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as CaHPO₄) 35 mg. • Phosphorus (as CaHPO₄) 27 mg. • Fluorine (as CaF₂) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K₂SO₄) 5 mg. • Manganese (as MnO₂) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as Na₂B₄O₇·10H₂O) 0.1 mg. Bottles of 100, 1000.

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Congress Makes \$4,365,250 Available To Hoosier Hill-Burton Projects

According to A. C. Offutt, M.D., Secretary of the Indiana State Board of Health, Hill-Burton funds totaling \$4,365,250.00 for hospital and related facilities construction made available to Indiana by the last Congress will be allocated to sponsors of community projects in a number of Indiana cities and towns. The projects and their tentative allotment of grant-in-aid funds are:

New community general hospitals at Winamac and Auburn for \$270,000.00 and \$610,000.00 respectively;

Additions to:

	Funds Allotted
McCray Memorial Hospital, Kendallville	\$ 350,000.00
Daviess County Hospital, Washington	350,000.00
White County Memorial Hospital, Monticello	180,000.00
Memorial Hospital of Floyd County, New Albany	1,121,477.00
Henry County Hospital, New Castle	400,000.00
Parkview Memorial Hospital, Inc., Fort Wayne	40,000.00
St. Joseph Hospital, Fort Wayne	638,956.00

Protestant Deaconess Hospital, Evansville	151,005.00
The Elkhart Rehabilitation Center, Elkhart	75,000.00
A new psychiatric facility in Elkhart, \$300,- 000.00.	

These allotments were made, Dr. Offutt said, in accordance with a priority list contained in the Indiana Hospital, Medical Facilities and Health Center Plan, a document which is intended to promote an orderly and equitable development of health facilities throughout the state. This plan, which should be of interest to any community planning to improve its health facilities, is available at the Indiana State Board of Health for review.

Among its important features are an inventory of existing Indiana hospitals, nursing homes and rehabilitation centers and recommendations for additional facilities. The plan is also of value to administrators concerned with keeping facilities abreast of the needs of our growing population. The current plan shows that general hospital beds are just barely keeping pace with population growth. In 1959 and 1960, we had 3.1 beds per 1,000 population. This com-

Continued on page 548

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Soma is unique because it combines the properties of an effective muscle relaxant and an independent analgesic in *a single drug*. Unlike most other muscle relaxants, which can only relax muscle tension, Soma attacks both phases of the pain-spasm cycle at the same time.

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pain and spasm fast, effectively . . . help give your patient the two things he wants most: relief from pain and rapid return to full activity.

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only with higher dosages. Soma is available in 350 mg. tablets. Usual dosage is 1 tablet q.i.d.

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**How you can help save
your patients a month's pay**

Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

NEWS NOTES

Continued from page 545

pared with 4.5 beds per 1,000 which is generally recommended as needed. The plan also reveals additional mental and chronic hospital beds, nursing home beds and rehabilitation facilities are needed. The shortage of facilities for the long-term patient, as reflected in this plan, warrant immediate attention, Dr. Offutt said.

Motion Picture Reviews Available

The latest edition of the annual publication "Reviews of Medical Motion Pictures" is now available upon request. It contains all of the reviews published in *The Journal A.M.A.* from Jan. 1 through Dec. 31, 1960. These reviews provide a brief description and an evaluation of motion pictures which are available to the medical profession. Each film is reviewed by competent authorities and every effort has been made to publish frank, unbiased comments. The booklet is prepared and distributed by the American Medical Association, Communications Division, Department of Medical Motion Pictures and Television, 535 North Dearborn Street, Chicago 10.

Three New Divisions Established by Public Health State Services Bureau

Establishment of three new divisions in the Bureau of State Services of the Public Health Service was announced recently by Surgeon General-Designate Luther L. Terry.

The three new divisions—Accident Prevention, Chronic Diseases, and Community Health Practice—are created as part of a Service-wide reorganization designed to strengthen and expand present programs and to provide more assistance to state and community health departments.

The new Division of Community Health Practice, with Dr. James K. Shafer as its chief, will support research to find ways of improving public health practices and medical care administration; assist states and communities in strengthening migrant health, metropolitan, school and other health services; and administer traineeship programs to increase the quality and supply of public health manpower. Most of these functions were performed by the Division of General Health Services, which has now been abolished.

The Accident Prevention Division, headed by Dr. Albert L. Chapman, will cooperate with state

Continued on page 552



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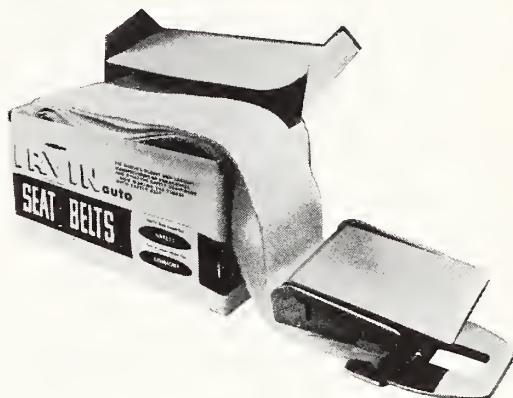


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In the opinion of the American Medical Association, between 8,000 and 10,000 lives would have been saved in 1960 if the occupants of the cars involved in accidents had been wearing seat belts. Convinced of the value of seat belts, and dismayed by their lack of public acceptance, the A.M.A. in 1958 joined the National Safety Council and the U. S. Public Health Service in a campaign to sell the seat belt concept. A.M.A. participation in the project was suggested by its Committee on Medical Aspects of Automobile Injuries and Death, a group firmly sold on the importance of such belts in injury reduction. Smart drivers use seat belts . . . how about you?

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NEWS NOTES

Continued from page 548

and local health and other agencies in developing and improving local accident prevention work, particularly in relation to highway safety, home accidents and accidental poisonings.

The Division of Chronic Diseases, with Dr. Leslie W. Knott as its chief, will deal with the prevention and control of cancer, diabetes, arthritis, heart disease, deficiencies of sight and hearing, and will focus especially on health problems of the aged.

The functions now given the Division of Chronic Diseases and the Accident Prevention work were formerly performed by the Division of Special Health Services, which is now abolished.

The organizational changes announced are based on recommendations of a task force appointed last January to consider how the Public Health Service should be organized to deal more efficiently with major public health problems of the next decade.

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Hoosier GP's Meet Mar. 14-16 For Annual Scientific Session

Hoosier general practitioners gathered in Indianapolis March 14-16 for the thirteenth annual scientific session of the Indiana Academy of General Practice.

The Board of Directors, officers and House of Delegates met on March 14, with scientific programs and exhibits opening on March 15.

Included on the program were Mr. Eugene P. Cornett, Indianapolis; Dr. Harvey Kravitz, Chicago; Dr. Morton Leeds, Indianapolis; Dr. Milton J. Miller, Evansville; and Dr. Irvine H. Page, Cleveland.

Also, Dr. John G. Walsh, Sacramento, Calif.; Dr. George Crile, Jr., Cleveland; Dr. Joseph L. Morton, Indianapolis; Dr. George J. Garceau, Indianapolis; Dr. George W. Crane, Chicago; Dr. William M. Browning, Indianapolis; Dr. Floyd A. Boyer, Indianapolis; Dr. Donald W. Brodie, Indianapolis; and Dr. A. F. Goldfarb, Philadelphia.

Dr. Francis L. Land, Fort Wayne, delivered the address at the annual dinner-dance following his installation as president.

Elected Radiology Fellows

Three Hoosier physicians have been elected Fellows in the American College of Radiology, according to a recent announcement from the College headquarters.

They are Drs. Robert E. Beck, Evansville; Chester A. Stayton, Jr., Indianapolis; and William A. Tosick, Indianapolis.

Investiture was made Feb. 10 in Chicago as a highlight of the Annual Meeting of the College and Conference of Teachers of Clinical Radiology. ◀

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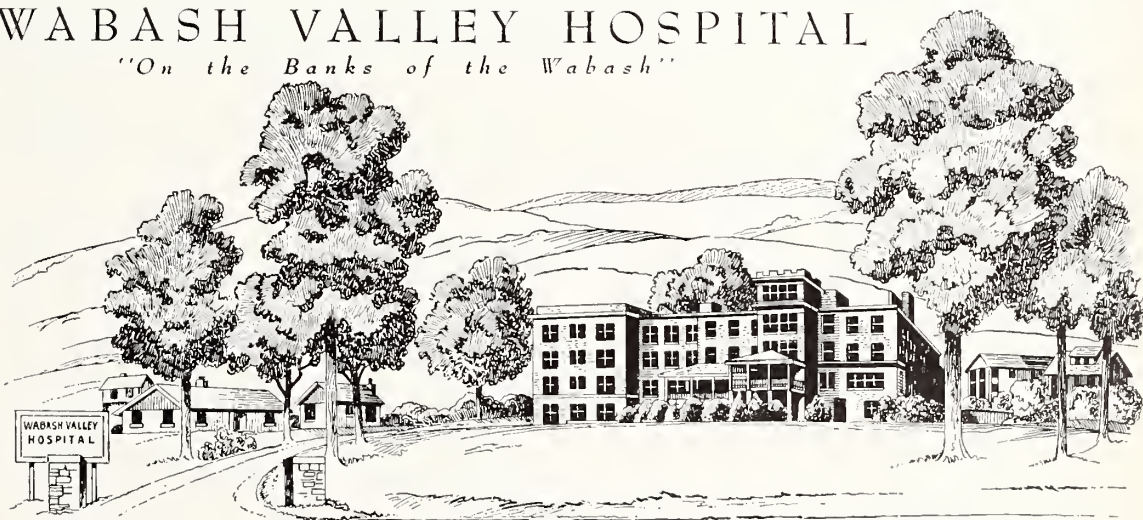
The eager-to-please hastess turned to the guest of honor and gushed: "I suppose I can't offer you wine. You are the head of the Temperance League, aren't you?"

"No," he replied, "I'm head of the Anti-Vice League."

"Well," the flustered hastess explained, "I knew there was something I wasn't supposed to offer you."—Leisure.

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FUTURE MEETINGS, SEMINARS, COURSES

Medical Assistants to Meet April 22-23 in South Bend

The Fifth Annual Convention of the Indiana Association of Medical Assistants will be in South Bend at the Pick-Oliver Hotel, April 22-23, with the St. Joseph County Chapter as hosts. Early registration will take place the afternoon of April 21. Saturday the 22nd will feature a tour of the Lobund Laboratory and Notre Dame Campus, a luncheon with Dr. Walter Portteus, Franklin, as speaker, an interesting and well-staffed workshop in the afternoon, and a banquet that night, with Rev. Leo Ward of Notre Dame as speaker. Sunday the 23rd is set aside for a breakfast meeting, two business sessions, and a luncheon, at which time G. Herbert True will speak on creative thinking.

PHYSICAL THERAPY ASSOCIATION SCHEDULES JULY CONFERENCE

The 38th Annual Conference of the American Physical Therapy Association will be held at The Palmer House in Chicago, July 2-7.

Theme of the scientific program will be, "Aftercare Programs," dealing specifically with the pediatric patient, the ambulatory adult and the geriatric patient.

Radium Society Chooses Colorado Springs

The American Radium Society will hold its 43rd annual meeting at the Broadmoor Hotel, Colorado Springs, May 11-13.

Scientific sessions will include papers on the treatment of gynecological cancer and cancer of the upper air passages.

Further information may be obtained from Dr. J. A. Del Regato, Chairman of Arrangements, Penrose Cancer Hospital, 2215 N. Cascade Ave., Colorado Springs.

Public Health Meeting Set

The 37th annual conference of the Public Health Association will be at the West Virginia University Medical Center in Morgantown, May 10-12.

In-Service Psychiatric Training Available to R.N.'s in Indiana

The State Committee on the Care of Mental Patients in General Hospitals has announced plans for an in-service training program in psychiatric nursing for registered nurses working in general hospitals.

To be given in some state mental hospitals in Indiana, the program is made possible by a financial grant from the Indiana Kappa, Kappa, Kappa, Inc., with cooperation of the Indiana Division of Mental Health.

Course of study will last approximately three months. There are five stipends of \$450, available to accepted applicants, and payable monthly in \$150 amounts. Further information may be obtained from Miss Janet Craig, 1330 West Michigan St., Indianapolis.

Kentucky Pediatricians to Convene

Members of the Kentucky Pediatric Society will meet at 2:00 p.m., April 20, at the Brown Hotel, Louisville.

Speakers will include Dr. Robert Ward, Professor of Pediatrics, University of Southern California, and Physician and Chief of Pediatrics, Children's Hospital, Los Angeles, on "New Developments in Viral Hepatitis;" and Dr. Samuel Kaplan, Director of Cardiology Department, Children's Hospital, Cincinnati, "Bed-side Diagnosis of Heart Disease in Children."


Briton Speaker at Canadian Clinic

Prof. Ian Aird, of the University of London, England, will be among the speakers at the Essex County Medical Society Surgical Clinic in Windsor, Ontario, Canada, Apr. 26-28.

Also included on the program is Prof. Robert M. Zillinger, Professor and Chairman, Department of Surgery, Ohio State University.

Further information may be obtained from the Registrar, 301 Canada Building, Windsor, Ont.

Continued on page 556



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Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed — *often in a few days*. She eats well, sleeps well and soon returns to her normal activities.

Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

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And although amphetamine-barbiturate combinations may counteract excessive stimulation — *they often deepen depression*.

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Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

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FUTURE MEETINGS

Continued from page 552

AMA Regional Medicolegal Conference Set for April 14-15 in Louisville

A Regional Medicolegal Conference, sponsored by the American Medical Association's Legal and Socio-Economic Division, will be presented in Louisville, Ky., April 14-15.

It will feature such speakers as Crawford Morris, Cleveland, an authority on res ipsa loquitur; Lou Ashe, San Francisco, immediate past-president of the National Association of Claimants' Compensation Attorneys; and Judge Irving Goldstein, Skokie, Ill., co-editor of *The Medical Trial Quarterly*.

May 15 Deadline for Heart Abstracts

The annual meeting and scientific sessions of the American Heart Association are scheduled for Bal Harbour, Miami Beach, Fla., Oct. 20-24. May 15 is the deadline for submitting abstracts of papers to be presented. Abstract forms may be obtained from Dr. Richard E. Hurley, Medical Associate, AHA, 44 E. 23rd St., New York 10.

Genito-Urinary Surgeons To Meet in Florida

Pebble Beach, California will be the site of the May 10-12 meeting of the American Association of Genito-Urinary Surgeons. Dr. William J. Engel, Cleveland Clinic, 2020 E. 93rd St., Cleveland, may be contacted for further information.

Medical Historians Schedule Convo

The American Association for the History of Medicine will meet at the Shoreland Hotel, Chicago, May 18-20. Those interested in attending may write to Dr. John B. Blake, Smithsonian Institution, Washington 25, D. C.

Internists to Meet in Florida

The American Society of Internal Medicine is scheduling a May 5-7 meeting at the Eden Roc Hotel, Miami Beach, Fla. Mr. G. Tod Bates, 350 Post St., San Francisco 8, may be contacted for further information. ◀



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50 mg. • L-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as CaHPO₄) 35 mg. • Phosphorus (as CaHPO₄) 27 mg. • Fluorine (as CaF₂) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K₂SO₄) 5 mg. • Manganese (as MnO₂) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as Na₂B₄O₇·10H₂O) 0.1 mg. Bottles of 100, 1000.

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INDIANA STATE BOARD OF HEALTH

Monthly Report — February, 1961

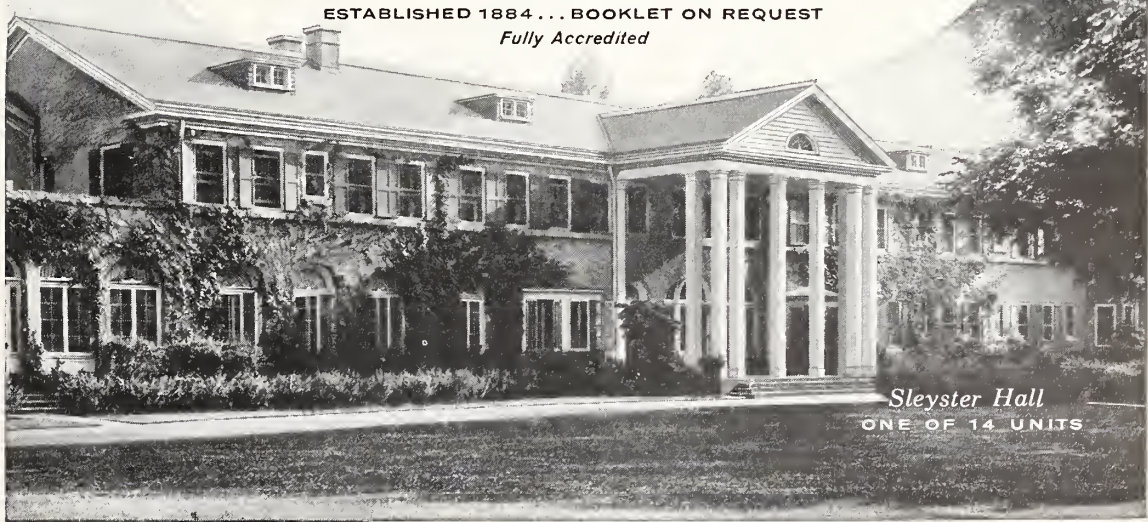
Disease	Feb. 1961	Jan. 1960	Dec. 1960	Feb. 1960	Feb. 1959
Animal Bites	334	212	289	224	189
Chickenpox	897	693	507	1068	752
Conjunctivitis	150	61	87	152	53
Diphtheria	0	0	1	2	0
Dysentery, Unspecified	94	12	16	50	19
Impetigo	88	62	162	76	65
Infectious Hepatitis	234	123	162	91	49
Infectious Mononucleosis	14	35	23	19	21
Influenza	495	584	1065	11387	1011
Measles (Rubeola-Rubella)	835	562	335	940	755
Meningitis, Meningococcal	2	2	3	2	2
Meningitis, Other	2	2	12	12	7
Mumps	469	343	364	298	227
Pertussis	9	12	13	39	137
Pneumonia	237	196	213	341	257
Poliomyelitis	0	0	13	0	0
Streptococcal Infections	874	541	569	1048	1048
Tinea Capitis	27	7	31	38	45

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Deaths

Charles Allen Bishop, M.D.

Dr. Charles Allen Bishop, 64, South Bend internist associated with the South Bend Clinic, passed away Jan. 31 as a result of a fall.

Dr. Bishop had practiced in South Bend for 34 years. A Canadian, he was a 1923 graduate of the University of Toronto.

Herbert Miller Baitinger, M.D.

Dr. Herbert Miller Baitinger, Gary physician and surgeon since 1923 and the steel city's most eminent Civil War scholar, passed away Feb. 16 at his office.

A past president of the 10th District Medical Society, Dr. Baitinger was a graduate of Northwestern University. He was general chairman of the exhibit committee of the Lake County Civil War Centennial Commission.

O. G. Brubaker, M.D.

Dr. O. G. Brubaker, practicing physician in North Manchester for 40 years, passed away Jan. 28 after an eight months' illness.

A former teacher, Dr. Brubaker attended Mount Morris College, in Illinois, and was graduated from Rush Medical College in 1906.

Dr. Brubaker began his practice at Mt. Morris in 1906, and in 1913 took his family to Liao Chou Shansi, China, where he served a seven-year term as medical missionary for the Church of the Brethren. He located in North Manchester upon his return in 1920.

Dr. Brubaker was a former secretary-treasurer of the 11th District Medical Society and former president of the Indiana State Academy of Eye, Ear, Nose and Throat.

Harvey B. Decker, M.D.

A veteran Terre Haute physician, Dr. Harvey B. Decker, passed away Feb. 21 at the age of 75. He had practiced in Terre Haute for 40 years.

Dr. Decker, who retired in 1959, was a former president of the St. Anthony Hospital staff. He was a 1917 graduate of the I. U. School of Medicine and served for two years in the Army Medical Corps before beginning practice in Terre Haute.

John H. Green, M.D.

Dr. John H. Green, 73, retired North Vernon physician and the third generation of his family to enter practice at North Vernon, passed away Feb. 14.

Dr. Green was a member of the State Board of Health for eight years, and served as president of the board two years. He was draft board examiner in World War II, and lieutenant in the Army Medical Corps in World War I.

In ISMA, Dr. Green was active on several committees. He served as secretary of his county medical society for several terms, and was an ISMA delegate twice.

George N. Herring, M.D.

Dr. George N. Herring, 70, physician at the Richmond State Hospital, passed away Feb. 8.

Dr. Herring had been on the medical staff of the hospital since 1952, having come there from Piercetown, where he had practiced for 26 years.

Prior to entering private practice, Dr. Herring was a medical missionary in China.

He was a graduate of Wake Forest College and received his M.D. degree from Jefferson Medical College, Philadelphia.

John H. Hewitt, M.D.

Dr. John H. Hewitt, 77, former president of the State Board of Health, passed away recently at his Washington, D. C., home.

Dr. Hewitt was Indiana's first relief director, serving in this capacity 1931-1934.



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He attended the University of Louisville Medical School, then practiced in Terre Haute from 1909 to 1926.

He was a member of the State Board of Health from 1917 to 1923, and served four years as its president. Dr. Hewitt was named manager of the Marott Hotel, Indianapolis, in 1941.

Elected to the State Senate from Sullivan and Vigo counties in 1930, Dr. Hewitt was appointed state coal director that same year by the Governor. He served on several ISMA committees from 1928-46.

Paul S. Johnson, M.D.

Dr. Paul S. Johnson, former superintendent of the Richmond State Hospital, passed away Feb. 6 at his Richmond, Ind., home. He was 81.

County Society News

Allen

Dr. C. Allen Good, of Mayo Clinic, spoke on "Facts and Figures Which Influence the Treatment of the Solitary Pulmonary Nodule" at the Feb. 7 meeting of the Allen County Medical Society in Fort Wayne. There were 85 members present.

Bartholomew-Brown

Dr. Joseph Black spoke at the Feb. 8 meeting of the Bartholomew-Brown Medical Society at Columbus. The group has started action toward establishing a local tumor clinic.

Carroll

Dr. J. C. Jones, Logansport, spoke on "Neonatal Jaundice" at the Jan. 18 meeting of the Carroll County Medical Society. The doctors and their wives also met on Feb. 15.

Clay

Dr. Richard Mehne is the new president of the Clay County Medical Society. Assisting him are Drs. Donald B. Garvin, vice president; Forrest R. Buell, secretary-treasurer, and Charles Moon, delegate.

Clinton

Newly-elected officers of the Clinton County Medical Society include Drs. Charles Bush, president; Francis Caryl, vice president; Chester Waits, secretary; and Robert Hedgecock and Dr. Bush, delegate and alternate delegate, respectively.

Dr. Johnson practiced at Gary and Sheridan after graduating from the Medical College of Indiana in 1903 and before being called to Army duty in 1918.

He became a staff physician at the state hospital in 1921 and later was in private practice, prior to being named hospital superintendent, from 1940-42.

J. C. Stafford, M.D.

Dr. J. C. Stafford, one of Indiana's oldest practicing physicians, died Feb. 15 while attending a patient in his Plainfield office. He was 79.

Dr. Stafford had practiced in Indiana since 1908, after graduation from Indianapolis Medical College. He was active in Plainfield civic affairs, having served as president and a charter member of the local Lions Club, and belonged to the Masonic lodge and Knights of Pythias.

Daviess-Martin

Dr. Robert Rang was recently elected president of the Daviess-Martin Medical Society. Other new officers include Drs. Glen Ross, vice president; C. Philip Fox, secretary-treasurer and

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COUNTY NEWS

Continued

delegate; E. B. Lett, delegate; and Dr. Rang and Dr. R. H. Chattin, alternates.

Decatur

Ten members of the Decatur County Medical Society met Feb. 21 for a dinner meeting and a film and discussion on Social Security disability claims.

Dubois

Seventeen members of the Dubois County Medical Society met at Huntingburg Feb. 9 for a general business session.

Floyd

Dr. Paul Patrick Hess spoke on "The Approach to Obesity in Children" at the Feb. 10 meeting of the Floyd County Medical Society.

Fountain-Warren

Ten members and 11 guests of the Fountain-Warren Medical Society met at Dr. Peter Petrich's home in Attica Feb. 2 for a business meeting.

Fulton

Newly-elected officers of the Fulton County Medical Society are Drs. C. L. Richardson, pres-

ident; Howard Rowe, vice president; and W. J. Rusler, secretary-treasurer.

Grant

Dr. J. P. Powell is the new president of the Grant County Medical Society. Assisting him are Drs. John Woodbury, vice president, and E. S. Rifner, secretary-treasurer.

Jasper-Newton

Dr. Edward Jones spoke on "Radiologic Complications with Perforating Ulcers" at the Feb. 8 meeting of the Jasper-Newton Medical Society.

Hancock

Newly-elected officers of the Hancock County Medical Society are Drs. James Garrison, president; Donn R. Hunter, vice president; Ted C. Kirby, secretary-treasurer; D. D. Gill, delegate; and Wayne H. Endicott, alternate.

Huntington

Dr. Paul Doermann spoke on "Experience in New Guinea as a Medical Missionary" at the Feb. 14 meeting of the Huntington County Medical Society.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SPRING, 1961

Surgical Technic, Two Weeks, June 5
Surgery of Colon and Rectum, One Week, June 5
Gallbladder Surgery, Three Days, June 19
Surgery of Hernia, Three Days, June 22
Blood Vessel Surgery, One Week, May 15
Thoracic Surgery, One Week, June 19
General Surgery, One Week, May 8
General Pediatrics, Two Weeks, May 1
Advanced Electrocardiography, One Week, June 19
General Practice Review, One Week, May 22
Neuromuscular Diseases of Children, Two Weeks,
June 12
Hematology, One Week, June 12
Gynecology, Office & Operative, Two Weeks, June 12
Vaginal Approach to Pelvic Surgery, One Week,
May 15
Obstetrics, General & Surgical, Two Weeks, May 1
Fractures & Traumatic Surgery, Two Weeks, June 12

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Jay

Twenty-five members of the Jay County Medical Society met at Portland Feb. 1 to view the film, "Disability Decision by Old Age and Survivors Insurance."

Kosciusko

Dr. George Haymond is the new president of the Kosciusko County Medical Society. Assisting him are Drs. Robert Dormire, vice president, and William Cron, secretary-treasurer.

Miami

Newly-elected officers of the Miami County Medical Society are Drs. L. L. Hill, president; E. E. Shrock, vice president; P. W. Snyder, secretary-treasurer; R. E. Barnett, delegate; and L. L. Hill, alternate.

Montgomery

Dr. James McFadden led a discussion concerning the American Cancer Society at the Feb. 16 meeting of the Montgomery County Medical Society. There were 23 doctors present.

Perry

Dr. H. R. Bush spoke on the 1931 epidemic of Meningococcic Meningitis at the Feb. 7 meeting of the Perry County Medical Society. Eight doctors attended.

Porter

Dr. L. Z. Sacks discussed some pathological problems at the Jan. 31 meeting of the Porter

County Medical Society. They were 16 members present.

Randolph

Dr. L. B. Chambers is the new president of the Randolph County Medical Society. Assisting him are Drs. L. W. Painter, vice president; C. R. Chambers, secretary-treasurer; Dr. Painter, delegate; and Dr. B. D. Wagoner, alternate.

Steuben

Newly elected officers of the Steuben County Medical Society are Drs. Wayne Schrepferman, president; M. H. Cameron, vice president; and L. L. McCormick, secretary-treasurer.

Wayne-Union

Wayne-Union Medical Society members have named Dr. Morris Snyder president for 1961. Other new officers are Drs. James Logan, vice president; Tom S. Shields, secretary; James Daggy, treasurer; Glen Ward Lee and Frank Lewis, delegates; Dr. Shields and Dr. C. G. Clarkson, alternates.

Dr. Pasquale Genovese, Indianapolis, spoke on "Mitral Heart Disease" at the group's Feb. 14 meeting.

White

Newly-elected officers of the White County Medical Society are Drs. Martin Dickerson, president; S. E. McClure, vice president; John C. Carney, secretary-treasurer; Jesse P. Galbreth, delegate; and Frank L. Baynes, alternate. ◀

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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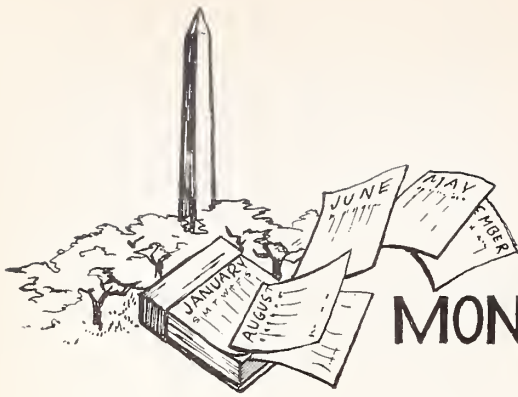
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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D.C.—The seriousness of the national problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the overall problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

RECOMMEND REFORMS, EXPANDED FACILITIES

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past 10 years but that the need for adequate facilities for humane, healing treatment of the mentally ill is still largely unmet.

More than half of the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels—federal, state and local—for public mental patient services be stepped up in the next decade from the present \$1 billion a year to \$3 billion a year.

Another recommendation was that there be a fully-staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing every national association and non-government agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

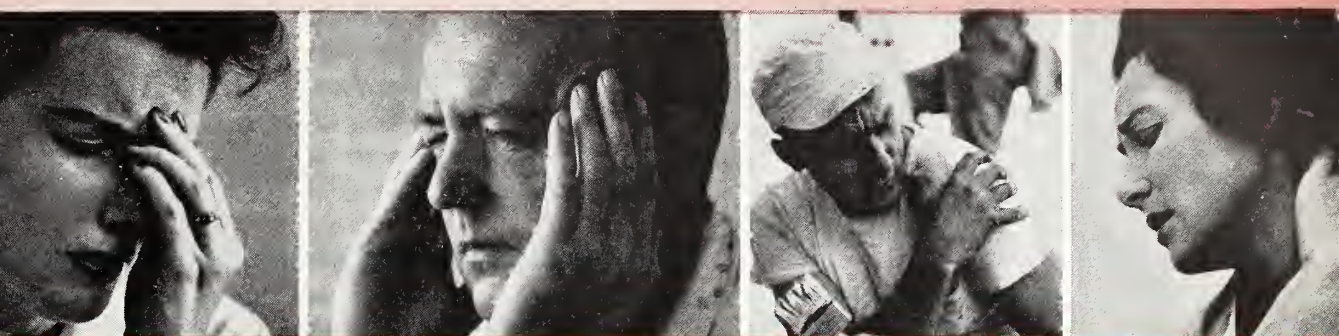
The government advisory committee, composed of 12 state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services."

Dr. Luther L. Terry, Surgeon General of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Dr. Winfred Overholser that there is no foundation to charges that many Americans are "railroaded" into mental hospitals. Dr. Overholser is superintendent of St. Elizabeth's Hospital, large federal mental institution in Washington, D.C.

Continued

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Dr. Lauren H. Smith, vice chairman of the AMA's Council on Mental Health, told the subcommittee that the AMA's future program in the field will include emphasis on more use of psychiatry in geriatrics, pediatrics and medical education, both at student and post-graduate levels.

Other activities planned for the AMA program include closer coordination of activities of the AMA council and corresponding committees of state medical societies.

LITTLE DRUG COUNTERFEITING

The Food and Drug Administration, after the government filed suit against two drug firms for counterfeiting, reported that an extensive investigation showed that there is still relatively little counterfeiting of drugs.

Of 2,700 samples of drugs collected from 900 drugstores in the first three months of this year, only nine were found to be counterfeit.

FDA Commissioner George P. Larrick said he expected the problem of counterfeit drugs to continue because of the lure of easy profits. But he said results of the investigation supported the FDA view that "the facts to date do not warrant disturbing sick people about the quality of medications that they have been taking."

In the counterfeiting suit, General Pharmacal Co., Hoboken, N.J., and Lowell Packing Co., Long Island, N.Y., and eight officials of the two firms were charged with manufacturing counterfeit tranquilizers, diuretics, weight reducers and other drugs and selling them to drugstores in six states. The Justice Department charged that the companies put markings on pills making them appear like other trademarked brands.

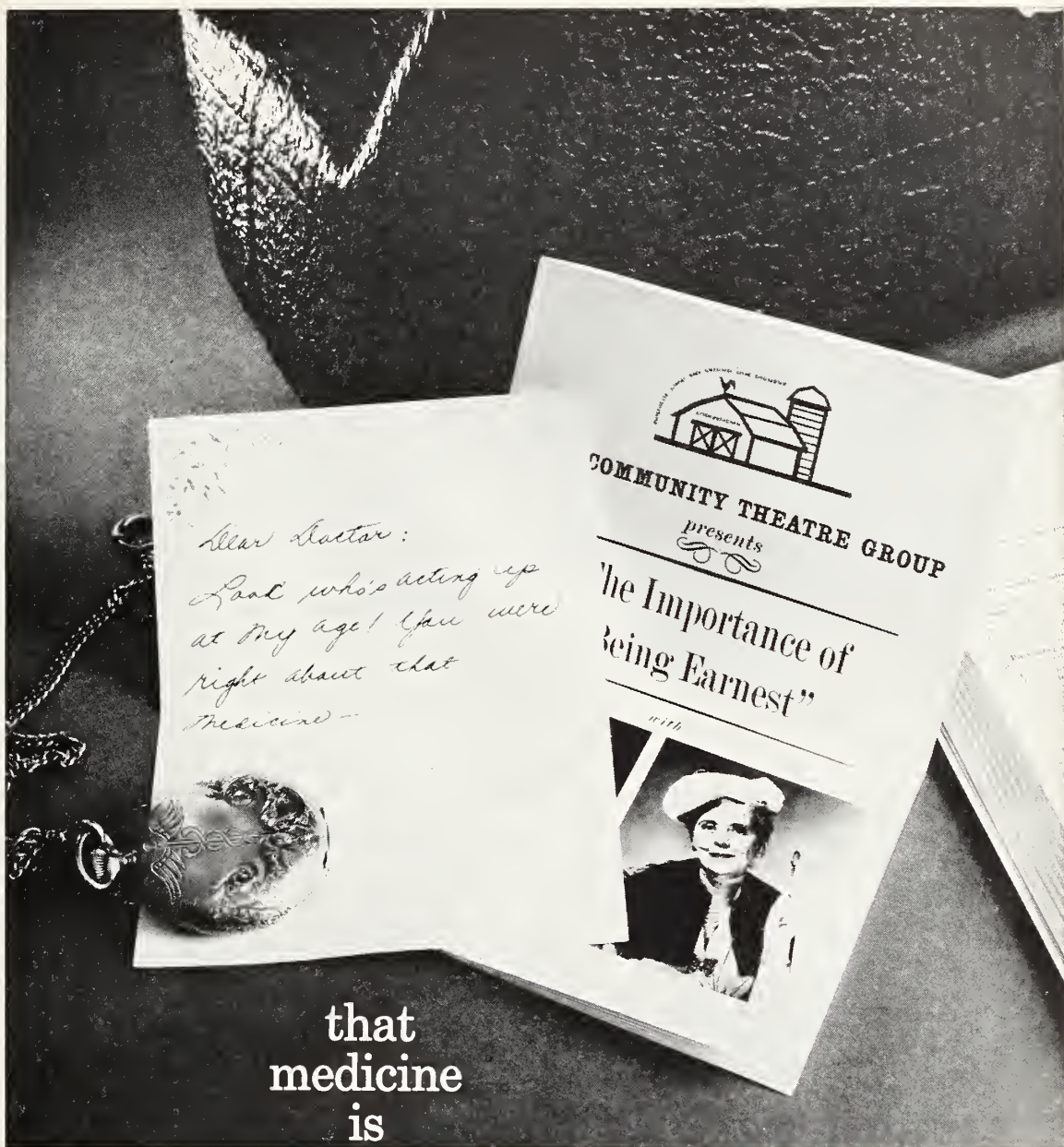
FDA ordered manufacturers, effective May 27, to supply samples of new drugs for testing by the government agency prior to clearance for sale.

In the past, the FDA has relied largely on scientific data supplied by the manufacturers themselves in clearing a new drug as being safe for sale. The FDA tested the drugs only on a limited and occasional basis and after they had been put on the market.

The government is spending \$4.1 billion a year in the health field, a Senate Government Operations Subcommittee reported. In the most detailed report of its kind ever published by a government group, the Subcommittee, headed by Sen. Hubert H. Humphrey (D., Minn.), noted that \$1.1 billion of the total cares for sick members of the armed forces and their dependents in hospitals. The tab for Civil Service workers' sick leave totals \$315 million a year. About \$650 million a year is spent on medical research, with most of this carried out by the National Institutes of Health and the Veterans Administration.

250 PHYSICIANS TO BE DRAFTED

The government ordered 250 physicians drafted this year due to the failure of enough interns to sign up for military service. It is the first physicians draft in four years. All of the draftees will be assigned to the Air Force. A department spokesman said the draft call would not prevent individual physicians finishing internship this year from volunteering for Air Force medical duty.



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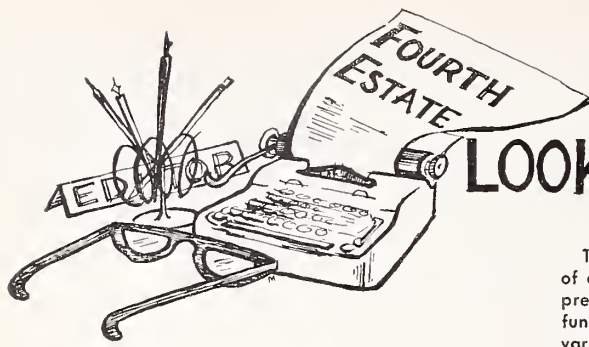
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Critic of AMA

Strong Feelings About Doctors

*By Robert C. Ruark**

In an age where it is no longer impossible to shoot down a hallowed old institutional image in flames, it seems to me that the saw-bones guild is making a big mistake in girding up the old loins to take on Jack Kennedy's old-age-assistance medical program with all the high-powered pressure forces at the doctors' command. Up to now the completely boiler-plated cynicism of the American Medical Association's mighty lobby has been fairly well submerged in the popular father-image of the kindly old Kildare in his modern eight-cylindere shay.

It has, you know, not been so long since a surgeon was merely a barber grown above his station, with the physicians cackling evilly over their gold-headed canes about the surgeon who absent-mindedly lathered a leg before he chopped it off. At that time the physicians were still nailing hospital windows shut to keep out the evil humors and distempers.

The doctor, in some instances with justice, has assumed in the short history of our country a ranking position with the clergy, the Boy Scout master and Santa Claus. His popular picture is that of the benevolent old Dr. Gillespie, as played by Lionel Barrymore; the aspiring but slightly silly young Kildare, as played by Lew Ayres; the scientific Arrowsmith played by

Ronald Coleman, and the intrepid surgeon who dives in where plumbers fear to tread as played by anybody with a made-up name like Rock Hudson.

Little has been said or done to replace these myths with the fact that the physician is blackmailed into membership of one of the toughest trade unions in the world, the AMA, which can wreck him if he bucks the union and which will cover up for him if he errs and is found out. Not much attention is directed to the fact that the doctor is the highest paid of all non-salaried professional men, on average income. Any time one mentions that the doctor runs his hospitals either as country clubs for the pamperage of rich hypochondriacs or as concentration camps for his own convenience, you can hear the hysteric howl as far down as the apprentice bed-pan slinger who lives in deadly fear of Doctor's Jovian displeasure.

Medicine's Grimier Aspects

No one likes to hear that organized medicine at times assumes the grimier aspects of both big business and the rackets, and that possibly there has been more undetected pilferage of income tax revenues by unscrupulous hard-money doctors than in any other ostensibly respectable profession. This is particularly true in the back-country areas, where few books are kept by the patient who pitches in a side of bacon and a couple of wrinkled five-dollar bills as payment

* Reprinted with permission of United Features Syndicate, New York, 17, N. Y., and of The Indianapolis Times, which published excerpts of the original article Dec. 28, 1960.



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FOURTH ESTATE

Continued

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You can also say that in the metropolitan areas the old-fashioned house call has joined the buggy as a means of communication between patient and physician. The diagnostician is now an answering service, and much of the trouble we have had with the antibiotics results from their lavish dispensation by doctors who can't be bothered to see the patient personally in his home.

You can also say that it is not a good idea to get sick on the week ends around the major cities. Doctor is generally away in the country, the mountains or by the sea. As for emergencies—a friend of mine recently picked up the phone to report an adult fever of 104° and the doctor refused to make the house call. Two friends of the friend helped him stagger to the office.

Doctors being human, you can sort out the segments of narcotics addicts, drunks, abortionists, outright quacks and racketeering psychiatrists as in the minority. You can also sort out the selfless, Hippocratically-dedicated together with the selfishly hypocritically undedicated as minority groups.

This leaves a majority of professional carpenters and plumbers and electricians whose domain is the human body, and who have come to view the ailing body as coldly and dispassionately as a sagging beam, a leaky faucet or a blown fuse. But they have also become accustomed to shrouding their mundane approach to treatment in all the astral mysticism and phony nobility which attends a craft of which the patient is as singularly ignorant as of metaphysics.

Highly Specialized Clubman

The patient is helpless in the power of the doctor, be he butcher or a shameless knave, and the doctor knows it and trades on it.

In short, during my span the doctor has come from the overworked general practitioner to the highly specialized clubman who conducts a hard business of dollars and cents with plenty of respect to ability to pay and working hours. When he attempts to protect his old semi-saintly immunity from criticism by fighting socialized medicine the hard way, he is monkeying with his luck.

He still protects his standing with a lot of witch-doctor mumbo-jumbo about prescriptions

and ethics, but the fact is that he has sold his curative function to the pharmacists—any of which, I might say, is equally competent to diagnose and prescribe as the London-suited low-handicap soothsayer on the other end of the phone. If the current American Medical Association attitude of "the public be damned" does not alter, in the face of change, the ghost of old Aesculapius is in for a hell of a nervous walk.

Gains for Mental Health

A good many Hoosiers will agree that one of the constructive things the recent General Assembly did was to vote money that will add 560 beds for the treatment and care of mentally retarded persons.

To finance the addition of 560 beds, the assembly appropriated more than \$4,000,000. In addition, it set up a \$250,000 program to evaluate the retarded in local communities and granted \$50,000 to design a new 200-bed training facility.

The state's mental health program was given a \$73,000,000 budget for the next two years, which represented an increase of \$10,000,000 over the present biennium.

A 40-hour work week was decreed for hospital workers, and funds also were voted for community psychiatric clinics and family-care programs. Money was given, too, for food and drugs.

Then the legislature created a separate Department of Mental Health, with divisions for the mentally retarded and emotionally disturbed children. These were gains in Indiana's enlightened overall program to attack mental ills.

Needed, but not appropriated, were pay increases for hospital workers, provisions for more professional personnel and larger funds for research and staff training programs. Yet there is a limit to what the taxpayers can pay, and the budget including the \$10,000,000 extra for mental health is already a red-ink budget. The state will be spending more than it takes in during the next two years, as it is. It cannot do everything that every special interest group wants done.

Kokomo Tribune

March 9, 1961

Who'll Enforce Safety?

Because the action bears on a bill now pending in the Indiana General Assembly, the offer by Chrysler Corporation to sell automobile seat belts on a non-profit basis is of particular interest.

Continued

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'The Walls Came Tumblin' Down' . . .



Site of new ISMA headquarters, 3935 N. Meridian St., Indianapolis, as it appeared on March 27 (left) and March 30. Workmen wrecked the old building in less than a week and groundbreaking ceremonies took place April 9.

FOURTH ESTATE

Continued

The big car manufacturer has said that it will provide belts to its dealers at cost. Chrysler will recommend to the dealers that they make the belts available to owners of cars regardless of make, on a non-profit basis.

The General Assembly has before it a bill which would make the installation of seat belts mandatory. Statistics have provided dramatic proof that safety belts do reduce injuries in automobile accidents to a remarkable extent.

Chrysler Corporation's approach, however, appears to be better than passing a law to enforce personal safety. Certainly this is a step taken only in the interest of the public, and without profit motive for either Chrysler or its dealers.

There are, it would seem, two flaws in the idea of "passing a law" to make Hoosiers protect themselves with automobile seat belts. In the first place, this law wouldn't really make driving safer for anyone. Speed limits do not prevent excessive speeds, and drunks will drive in spite of state statutes. To be effective, the belts have to be securely buckled. Has anyone guessed how many police would be required to enforce a statute which says you shall buckle your seat belt and the belt of any passenger in the car before proceeding on a trip? Who would be responsible for seeing that the belts were not unbuckled?

Safety belts are good, but they are no better than the individual who wants to use them. Chrysler Corporation offers that choice to each car owner. A state law which is impossible of enforcement on its face would simply create more contempt for highway safety than already exists.

Indianapolis Star

Feb. 4, 1961

Doctor Shortage

Last year the 81 accredited medical schools of the nation turned out 7,081 new doctors, which was only 104 more than in 1955. But the United States had gained 10 million in population during the five-year period.

There are now only 132 doctors for 100,000 people. This is regarded as a minimum. Yet plans to hold to this ratio by stepping up the number of doctor graduates in proportion to population increase are not yet even in the planning stage.

Five years from now medical schools must turn out doctors at the rate of 7,751 a year to hold the ratio. By 1980, 10,295 graduates will be needed annually.

In recent years several medical schools have been opened and some of the old ones have expanded their facilities. But an estimated 37 new schools will be needed to keep the pace. None of them are materializing.

For a time there was hope that medical graduates from other nations might fill the gap. But more than a fourth of them flunked one recent examination to meet our medical standards. An even larger proportion of foreign doctors taking overseas examinations to determine eligibility to come to America are not passing. More than 10,000 foreign doctors and interns are active in the U.S., but that source of supply seems to be drying up.

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FOURTH ESTATE

Continued

uates of American medical schools doctoring the American people.

Gary Post-Tribune
March 4, 1961

Opportunity Without Takers

Medicine today offers more opportunities and young persons are failing to take advantage of them.

This unhappy piece of intelligence comes from the American Medical Association. The number of applicants for admission to the nation's 85 medical colleges has been dropping. In 1947, for instance, nearly seven percent of all college graduates made applications to these schools. In 1958, only four percent did. There are known reasons why. The low birth rate of the '30's is one. Also, multiplying opportunities in other professional fields are believed to be diverting possible medical candidates.

The pity of it is, as the AMA points out, that those who pass up medicine today are doing so at a time when it has become one of the most rapidly progressing fields of all, offering maximum promise for a young man or woman. In 1940, medical research amounted to \$45 million—the 1960 figure was roughly \$600 million, and predictions for 1970 go as high as \$3 billion. The demand for medical researchers in the future will be matched only by the opportunities.

So far as the individual is concerned, the possible rewards are great, and the greatest one by far is the doctor's capacity to do so much good for so many people. All of us should want to leave the world a little better place because we passed through it. The M.D. degree offers one big way of doing that.

Terre Haute Tribune
January 6, 1961

For Future Treatment

When the General Assembly begins to consider requests for the state's mental health program, it should take a look at a recent report from a special committee of the Public Health Service. That report looks forward to the eventual elimination of large custodial hospitals for mental patients.

Instead, the mental hospital of the future may well be a small regional or community facility which can take advantage of the more important recent advances in care of the mentally ill. Patients would be allowed more freedom. The hospital would direct a program which would mesh with the general life of the communities, including occupational, educational, recreational and group therapy.

This report was presented recently by a committee of state and mental health authorities. Part of the findings shows a large recent increase in the care of mental patients in general hospitals. Where only 48 general hospitals admitted psychiatric patients in 1940, there are 515 such hospitals which provided psychiatric treatment for 183,000 patients last year.

The committee report recommends that the small psychiatric hospital should be part of a complete community program for the promotion of mental health.

Adopting such a sweeping change probably is not feasible in Indiana at this time. However, consideration must be given to the generally accepted idea that mental patients should be returned to community life rather than to maintain them in large custodial institutions. Certainly this report should be placed before the legislators when they begin to study present and future needs of mental health here.

Indianapolis Star
January 24, 1961

After the Goose Again

Senator Estes Kefauver's subcommittee, which conducted some dramatic investigations of drug prices in the past year, has announced a set of recommendations to reduce the prices of medicine by "breaking up rigid patent controls." Senator Kefauver said the idea is to spur competition in the drug industry.

We hope legislators and the public will examine the senator's patent-busting idea quizzically. It might help to put the rest of the proposals in perspective.

What kind of competition would be stimulated by breaking up patents? The action would, of course, spur various manufacturers of all sizes and kinds to get into the market and capitalize on the popular drug discoveries, the ones which run up a big volume of public sales.

Continued



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FOURTH ESTATE

Continued

But what about the making of the discoveries? Would the companies which pay the bills for the research laboratories be stimulated to work harder and make more new discoveries to be exploited by their competitors?

It may be true that a great many discoveries and inventions are the work of dedicated geniuses who toil for the sake of discovery and of service, without thought of wealth for themselves. Nevertheless in most fields it takes money—a lot of money—to provide the tools and materials for the study and experiment by which discovery comes.

It is one thing to grubstake research on the chance that a compensating profit may be made if the research produces a good discovery. It is quite another thing to put up the money if that chance for profit is missing.

When you're talking about such projects as search for wonder drugs, you're not talking in terms of peanuts. You're talking about money by the million. Neither the drug companies nor others are going to put up that kind of money unless they have a chance to profit from the results.

Is the field of drugs different, because it deals so intimately with human life and human suffering? Should the discoverers of wonder drugs therefore be willing, out of humanitarian considerations, to forego the crass motive of profit and let all comers have their patents? As a matter of fact this question falls apart of its own weight. How would breaking up patent controls spur any competition except through the hope of the competitors that they might turn a profit?

The profit motive, as a matter of fact, has spurred most of the world's material development. And let no one look down his nose at material development, for it in turn has made a pretty substantial contribution to culture and philosophy and the rest. The profits have helped, too.

Admittedly someone probably would have built the first automobile just for the challenge of it, whether or not anyone had a thought of making a dime out of it. But it's a cinch no one would have started figuring out ways to make automobiles for the mass market without the vision of profits on the horizon.

The control of patent over the use of an invention plays a vital part in the motivation for finding new ideas and, equally important, putting them to use so that the world can get the benefit of them. Who can calculate what marvels might never have seen the light of day if the inventor and his sponsor had lacked the protection of patent? Why should medicine be denied the stimulus of this protection?

Indianapolis Star
Dec. 26, 1960

Shut Up And Sit Down

Further information on the manner in which the White House Conference on Aging was conducted has only confirmed early comments made in these columns. The liberals screamed that the conference was "stacked," but they failed to point out that the session was rigged from the very beginning to produce exactly what they wanted.

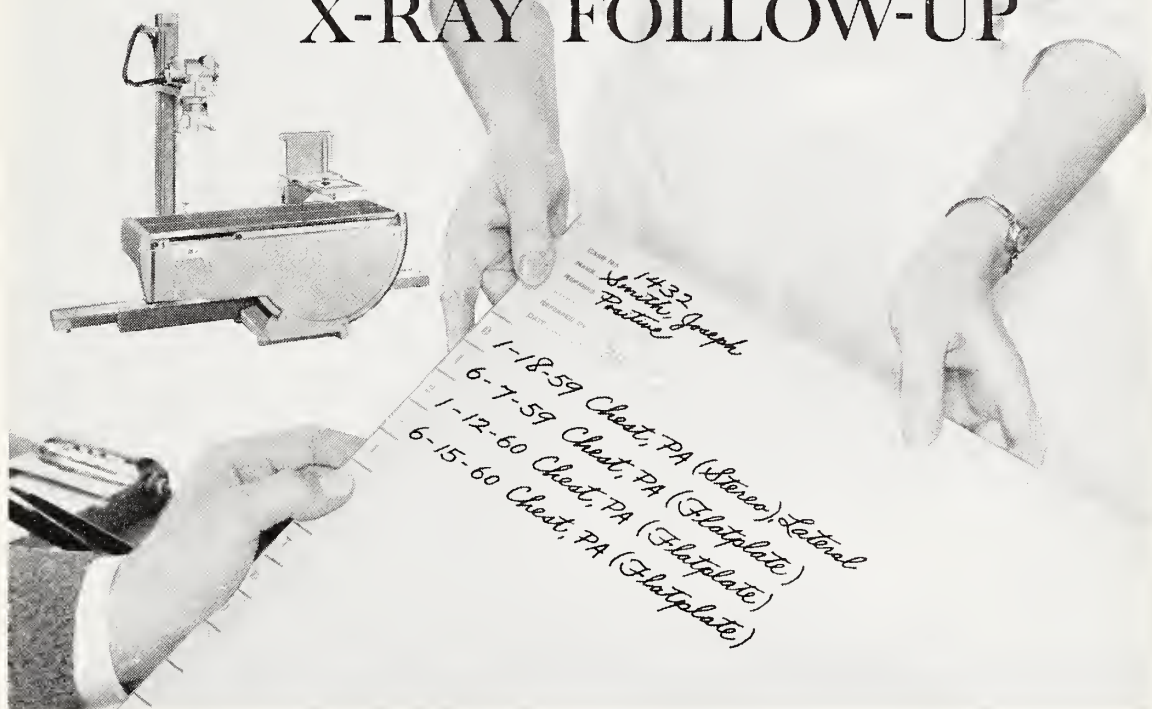
Dr. Morton Leeds of Indianapolis found out that he was not supposed to vote on any of the proposals made at the conference. He made the mistake of thinking that an official delegate had some voice in what was to happen, and asked for a ballot by the 2,475 registered participants in the meeting.

According to a ruling by Robert W. Kean, conference chairman, the only way such a vote could be held was to obtain the approval of two-thirds of the delegates. At the time he made this ruling, there were considerably less than the 1,650 delegates in the hall where Dr. Leeds made his motion. However, Kean whacked the gavel and announced that "1,650 having voted, I declare the motion lost." Neither Dr. Leeds nor any other maverick delegate was going to interfere with the smooth course of events at that conference, even if it took the public declaration of an obvious untruth.

Later, the conference was faced with two reports on the question of whether a health insurance plan should be tied to higher Social Security taxes. One section reported that this system should be used. Another section of that same conference came in with exactly the opposite idea—that Social Security should not be used. The conference chairman then directed those who wanted a voluntary system to withdraw their proposal.

In case you might have missed it, we will point out that the section with the "wrong" report

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FOURTH ESTATE

Continued

wasn't asked to reconsider its ideas or to file a dissenting opinion. In so many words, the section which refused to be "stacked" by the big-government liberals was told to shut up and sit down.

Those who supported higher Social Security taxes were reported to feel that muzzling Dr. Leeds was a victory. They are said to hold that the conference had not been set up either to permit open discussions or general votes.

The rest of the nation might well ask what sort of representative body this conference was, and for what reasons it was called together. In the light of these facts, the 2,475 delegates were nothing more than so many stage-props to be shoved around by the liberals, such as Kean and Prof. Wilbur Cohen.

It is a curious commentary on the liberal belief in democracy when an open discussion of the real question before the delegates was not permitted at this conference. There is something wrong when the delegates at such a conference can't vote on the central issue at stake.

The nation should be spared in the future the expense attendant on such phony conferences. A routine hand-out from Prof. Cohen's office would have served the same purposes, at considerably less cost to the taxpayers.

At least the nation can be grateful for faithful reporting of this "stacked" conference by newspaper reporters. The country can evaluate the outcome for what it really is, unadulterated liberal hokum.

Indianapolis Star

Jan. 20, 1961 ◀

It Follows

The following advertisement appeared in a physical culture magazine:

"Here's a good test for your stomach muscles. Clasp your hands over your head and place your feet together on the floor. Now bend to your right at the waist as you sit down on the floor to the left of your feet. Now, by sheer muscular control, haul yourself up, bend to the left, and sit down on the floor and bend to the right of your feet. Keep this up and let us know the result."

In a few days the first letter arrived. It said simply: "Hernio."—*Wall Street Journal*, Nov. 8, 1960.

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A System of Fluid Therapy

Water and electrolyte imbalance in children

KEITH HAMMOND, M.D.

Muncie

UNTIL THE PAST few years the principles of fluid therapy were presented in such a manner that the subject seemed extremely complicated. There were several reasons for this. The most important one was due to the older idea that fluids used for replacement must more or less accurately duplicate those lost in both amount and chemical make-up. The whole subject is still very complicated but the principles upon which therapy is based make clinical application to actual practice much simpler.

We now realize that even chemical studies of the blood serum do not necessarily reflect important fluid and electrolyte conditions within the body. The intracellular fluid status is all-important but is not reflected from moment to moment in the blood stream. Butler and Talbot noted that "the fluids retained by patients recovering from diverse types of fluid imbalance often bore little resemblance to the composition of the fluids administered. . . . It became apparent that every successful system of fluid therapy provides water and electrolytes in amounts which permit the body-regulating mechanisms to selectively utilize or discard them according to the body's requirements."¹

¹Presented before the Orange County Medical Society meeting, Spring Mill State Park, Jan. 5, 1960.

The body accomplishes this through its "homeostatic mechanisms." These mechanisms are complicated but they operate largely through the lungs and the kidneys. Of these, the kidneys are the most important so far as choice of therapy is concerned. However, the lungs participate in this regulatory capacity by virtue of their ability to retain or blow off carbon dioxide, depending upon respiratory exchange.

Kidney Function Range Enormous

Present-day therapy has been further simplified by the recognition that the range of function of the normal kidney is enormous. It is for this reason that dosages do not have to be figured exactly and chemical composition of the fluids used does not have to be like that of the plasma. Instead, one needs only to provide approximate but adequate amounts of water and only a relatively few electrolytes. The normal-acting kidney will choose what the body needs, both water and solutes, in the proper amounts.

This wide range of function of the kidneys is demonstrated by several commonly known facts: (1) it can acidify the urine up to a pH of 4.5; (2) it can concentrate the urine up to a specific gravity of 1.035 or better; (3) it can pass water which is almost as free of solute as tap water; (4) it will not spill bicarbonate unless the plasma CO₂ is about 28 mEq per liter; (5) it can allow only a small amount of water to pass daily or it can pass several liters if necessary. All of these

things are within the range of the normal healthy kidney.

Another innovation which has simplified fluid therapy was the adoption of the system of designating electrolytes in milliequivalents. By the old system actual weights were used. The electrolytes do not bear chemical relationships by weights. A gram of sodium and a gram of chlorine do not "use each other up" to form two gms of salt. On the other hand, a milliequivalent of sodium combines with exactly a milliequivalent of chlorine to form a millimol of salt. The old system was like inviting 500 pounds of girls and 500 pounds of boys to a party, hoping that there would be one female dancing partner for each boy. It just would not work out this way. Similarly all the ions must be paired—one positive (cation) equivalent for each negative (anion) equivalent—and this works out exactly when values are expressed in milliequivalents.

Surface Area Replaces Weight

The next innovation which has simplified things is the adoption of surface area, rather than weight, as a means of estimating requirements of fluids and electrolytes. By the old system one had to remember amounts per pound at various ages. By the square meter system age has nothing to do with it. The infant's dosage, on a square meter basis, is the same as the adult's on the same basis.

With these things in mind we will consider some other concepts which have made things simpler. In the first place it is recognized that of all the cations the most important one is sodium, so far as acid-base relationships are concerned. The most important anion is chloride. The most important buffer is sodium bicarbonate, but this seldom has to be administered as such except when acidosis is severe. As it works out in practice one can treat probably as many as 90% of patients with fluid balance problems with the following solutions in varying combinations:

Normal saline

5% glucose in distilled water

Potassium chloride in measured dose vials

One may occasionally need ampules of 7½% sodium bicarbonate and 3% sodium chloride in ampules or vials to supplement these. Also, one might want to use 10% glucose instead of 5% in some cases.

Because of the wide variation of normal renal

function and its great selectivity it has been found that fluid requirements can be estimated as follows:

For normal maintenance:

1500 cc./sq.m./24 hrs.

Moderate dehydration (5%):

1000 cc./sq.m./24 hrs.

(correction)

Severe dehydration (10%):

1500 cc./sq.m./24 hrs.

(correction)

Remember that these are only approximations and *you should use clinical judgement* and actual measurements such as weight loss or measured loss of fluids where there is drainage or measured output of urine.

It has been found that it is sufficiently accurate to estimate the square meters of surface from the weight, so that the average 150-pound man (about 70 kilos.) has a surface area of about 1.9 sq. m. There is a nomogram which goes as follows:

1 kilo. = .1 sq. m.

For each extra kilo. to 5 add .05 sq. m. so that

5 kilo. = .3 sq. m.

For each subsequent kilo. add .035 up to 40 kilo.

For reasons which we will not go into, if you replace all losses with normal saline you will usually be using too much salt. It is seldom necessary to use over half normal saline and in infants we seldom use over ⅓ normal saline.

In general, you can think of blood plasma as having 150 mEq of cation (most of which is sodium) per liter and 150 mEq of anion (most of which is chloride) per liter. Most of the companies have come out with fluids which are variously named, numbered or otherwise designated. Meads No. 48, for instance, has 48 mEq of each pair (+ and —) of ions per liter. In other words it is essentially ⅓ normal saline. However it also has potassium and other ions and is in 2½% glucose. Similarly, Meads No. 75 has 75 mEq of each pair of ions per liter in glucose in addition to other ions. Actually you can practice good fluid therapy without these specially-prepared solutions although their use simplifies matters. For purposes of our discussion here we can disregard all the other ions except sodium, chloride, potassium and bicarbonate.

Starting Hydration

Be sure to start the hydration with normal saline and D5W 1:1 or even 1:2 unless you are absolutely certain the kidneys are functioning. Most companies even make an initial hydrating solution for this purpose which has no potassium in it. Figure this initial hydration at about 350 cc. per sq. m. and adjust the flow so that it is absorbed in about 45 minutes. By then the kidneys will probably have acted and you can go to one of the prepared solutions or continue with a mixture of glucose and saline. You need be in no hurry in most cases about adding potassium and can often safely go for some hours before doing so. The potassium comes in measured dose vials, usually about 5 mEq/cc. (It will be indicated on the label.) Calculate the potassium requirement on the basis of 40 mEq./sq.m./24 hrs.

The simplest way to show how it is done would be to take an example. Suppose the patient is a 10-pound baby who has a diarrhea and is severely dehydrated as manifested by his clinical appearance. So far as we know the kidneys have not acted recently. It is not at all improper to start treatment without any laboratory work. For the initial hydration we choose N/S and D5W 1:1. He has a surface area of .5 sq. m.

$$.5 \times 350 = 175$$

Allow this 175 cc. to drip in fairly rapidly and along toward the end of 45 minutes to an hour he will probably have voided.

Since he is severely dehydrated we will calculate his requirements on the basis of 3000 cc./sq. m./24 hrs. Remember that this is only an estimate and as time goes on you may wish to increase it or decrease it, depending upon your clinical judgement.

$$.5 \times 3000 = 1500$$

Since the baby has diarrhea he is losing a lot of salt and it would also probably be best to give him nothing by mouth. However, it is unlikely that he should have over $\frac{1}{2}$ N/S. You can go to one of the prepared No. 75 or similar solutions now that he has voided or you can simply give N/S and D5W 1:1. That would be 750 cc. of each. He is to get 1500 cc. in 24 hrs.

$$1500/24 = 62$$

Round this off and call it 60 cc./hr. In order to determine the rate of flow you can divide the number of cc./hr. by 4 and get drops/min.

$$60/4 = 15 \text{ drops per minute}$$

This should be recorded at hourly intervals

so that the patient gets the approximately correct amount each hour.

Probably 80% of such babies can be treated in this manner without resort to laboratory work. Adults can be treated in the same way, the calculations being performed in the same manner. However, if the patient fails to respond promptly you should probably do some laboratory procedures. This, again, depends upon your clinical judgment and impressions as to the patient's condition, being quicker to resort to tests when dehydration seems severe.

Children More Difficult

In general children are more difficult to manage as far as their fluid and electrolyte is concerned. They make changes in clinical condition quicker and have to be watched. In any case the urine should be checked to see if the patient has any evidence of renal disease. Also, it is helpful to know if there is acetone in the urine. The more acidotic he is the more likely one is to find acetone. There, again, children act differently than adults. They become acidotic at the slightest provocation, particularly if they are not eating.

You can really do well with only three blood chemical determinations. These are the CO_2 , BUN (or NPN), and serum chloride. If you can get only one of these choose the BUN before all others because it gives you more vital information. If you get the CO_2 and the chloride you can estimate the sodium if the urine has no acetone in it by adding them to 15:

$$15 + \text{CO}_2 + \text{chloride} = \text{Sodium (approx.)}$$

If there is acetone the patient will be acidotic enough that the actual sodium will probably be much lower than this. However, in our laboratory we have a flame photometer and can get sodium and potassium determinations quite readily. Serum sodium is one of the finest indices of the state of electrolyte balance.

Suppose you find that the CO_2 is down about 7 or 8, the chloride about 110 or so and the sodium 125. In other words the patient is acidotic, has a very low sodium and about normal or slightly elevated chloride. (Such a patient may be found to have renal disease.) This state of affairs could be quickly remedied by giving $7\frac{1}{2}\%$ sodium bicarbonate. Figure this at 1.5 cc. per pound (or about 15 cc. in this case) to raise the CO_2 by mEq. It should not be raised more than this at a time. This can be given rather rapidly by drip.

Suppose the patient does not seem to have lost much actual water, might even seem a little edematous, but the sodium is 130, the chloride is also down, say to 90. In other words he needs both sodium and chloride rather badly. Calculate the deficit on the basis of the sodium level, using 142 mEq per liter as the average normal.

$$142 - 130 = 12\text{mEq}$$

The patient lacks 12 mEq/liter in his extracellular fluid. The extracellular fluid is 15% of the body weight in children (25% in adults). He weighs 5 kilo.

$$15\% \times 5 = .75$$

He has .75 Kilo. (or liters) of extracellular fluid and needs $.75 \times 12$ or 9 mEq of sodium and 9 mEq of chloride; 3% sodium chloride has .5 mEq/cc. so that you give 4.5 cc. of 3% sodium chloride. This should be given very slowly—about 1 cc./sq.m./min. ($\frac{1}{2}$ cc./min. in this case).

This oversimplifies the management of fluid balance problems, but it will work in the vast majority of cases. Just remember this—the problem is much more complicated in the presence of renal disease and cannot be properly managed without laboratory help.

Clinical Judgment Often Sufficient

Clinical judgment will often suffice in the average case. Take into consideration the nature of the fluid and electrolyte problem you are trying to solve. Is it almost all hydrochloric acid being lost, as in gastric suction? Bear down on the sodium chloride—the kidneys will take care of

the rest. Is it almost all salt and water, as in diarrhea? Give plenty of sodium chloride but you may need give additional sodium bicarbonate. Is it almost all water, as in the hyperventilation of aspirin poisoning? Give dilute saline. Is the patient extremely acidotic because of ketosis, as in diabetes? Give plenty of glucose along with the water and salt and plenty of insulin so that he can use his glucose and not form more ketone bodies by trying to utilize his fat. Is it almost all salt as in heat prostration? Give lots of salt and beware of water intoxication. If you simply want to supply fluids, electrolytes and nutrient while the patient is NPO it will be adequate for some time if you only give half saline and glucose water figured on a maintenance basis.

Ordinarily when in doubt give saline in strengths less than normal saline and remember that in infants it is relatively easy to get hypernatremia, even from orally-administered salt. This is a serious and dangerous complication. Ordinarily one does not give plain distilled water because it will cause hemolysis. The glucose in solutions with less than normal saline exerts a tonicity so that half normal saline and $2\frac{1}{2}\%$ glucose is approximately isotonic as is 5% glucose alone.

REFERENCE

1. Snively, William D. Jr., Sweeney, Michael J.: *Fluid Balance Handbook for Practitioners*, p. 125, Charles C. Thomas, Publisher, Springfield, 1956. ◀

2112 Petty Road,
Muncie

Supposedly Safe

Last year, according to National Safety Council statistics, some 9,300,000 citizens suffered fatal or disabling injuries with approximately half of these occurring in the supposedly safe confines of the home. In recent years, accidents have killed, maimed and crippled more children between the ages of one and 14 than the seven deadliest diseases combined, and are now the leading cause of death for all persons between the ages of one and 36.—*Nebraska State Medical Journal*, Vol. 46, No. 3.

—“by any
other name”—

Various Anginal Syndromes

A. D. DENNISON, JR., M.D.

Indianapolis

CLINICIANS ARE bombarded with eponyms that bring utter confusion to the problem of coronary artery disease and may thwart sensible efforts to establish efficient, effective and evolutionary forms of treatment. Certainly medical literature is replete with terms such as angina decubitus, status anginosus, crescendo angina, TV angina, postprandial angina and more recently the angina pectoris inversa syndrome. Finally, to add to the confusion and consternation one often sees the term intractable angina pectoris in the literature, and the whole field is compounded by name-calling with insufficient comprehension of the pathologic background. This leads to trial and error therapy.

Angina Decubitus

Angina decubitus and status anginosus are not necessarily synonymous, but elements of each may be. Angina decubitus depicts the development of anginal pain at rest and often manifests itself as nocturnal angina. Thus pain developing at rest is properly called angina decubitus. It may also be given the appellation, nocturnal angina. Certainly the occurrence of nocturnal angina should alert one to the possibility of occult or covert cardiac decompensation.

Status Anginosus

Status anginosus may be defined as repetitive attacks of angina pectoris, whether during the daytime with effort or at night at rest. Thus, an overlapping of terminology is obvious. If the discomfort occurs at night, at rest, it also fulfills the criteria of angina decubitus or the criteria of nocturnal angina. It connotes a more serious degree of insufficiency of the coronary vessels and may even signify an impending or actual acute myocardial infarction.

Television Angina

The term TV angina has popular appeal. Since the advent of television some patients have reported to their physicians that their angina is precipitated by events seen on television. This is particularly true of the emotional excitement that develops while the patient is watching boxing matches, wrestling matches, western programs or a program of violent and malevolent content, such as “The Untouchables.”

Crescendo Angina

“Crescendo angina” is closely akin to status anginosus and indicates a change in the pain-discomfort pattern from an occasional or infrequent anginal attack to a progressive increase in the frequency and severity of such episodes. Certainly one of the uncharming features of medical literature has been the advent of multiple terminologies, often closely related, often overlapping with previously accepted classical terminologies. Indeed this term, though descriptive, may be subject to just such a criticism. “Crescendo angina” possesses a common meeting ground with status anginosus. Again this clinical profile indicates a deepening insufficiency of the coronary vessels, a dynamic change in the patient’s problem, a possible impending myocardial infarction and a need for conservative therapy.

Postprandial Angina

A sense of completeness would involve mentioning postprandial or postcibal angina pectoris, but certainly this is self-explanatory and has no ominous pathologic import. In including this title one could make the list interminable—postcoital angina, postemotional angina, nicotine angina and *ad infinitum*.

A number of intriguing features play a part in postprandial angina. There is the obvious increased cardiac workload of splanchnic bed demands for digestion. But, in addition, one must point out the contributions and dangers of postprandial lipemia in increased sludging of flow, increased cohesiveness of cells and thus, increased clottability of blood.

Angina Pectoris Inversa Syndrome

Though still willing to remain close to Heberden's classical syndrome of angina pectoris it becomes necessary to define and clarify one additional term in this area of multiple terminologies. The syndrome of angina pectoris inversa has recently come into vogue. In this condition the episodes of pain referable to the heart generally occur during rest. Prinzmetal and his associates apparently first observed and reported this syndrome, which they consider to be a variant of classic angina pectoris. Because of its transitory character and the unlikelihood of cardiologists to get electrocardiographic tracings just at the proper time, the syndrome is observed much less often than ordinary angina. Elevation rather than depression of the S-T segments is observed in the electrocardiographic tracing during an attack, with reciprocal S-T depressions in other standard leads. These changes are similar in degree to those seen in acute myocardial infarction. The interesting feature is that as soon as the pain subsides, even within the space of a few minutes, the electrocardiographic changes return to normal. It is apparently usually impossible to reproduce these changes by various exercise tests. One can appreciate that the diagnosis can scarcely be confirmed, except by comparing electrocardiographic tracings obtained prior to or after the cessation of the pain.

Intractable Angina Pectoris

A definition of intractable angina may well differ according to the cardiologist who is managing, observing, discussing or presenting any given case. Symptoms of angina which persist for at least six months, despite every effort to eliminate or alleviate any possible contributory factors and despite the frequent use of nitroglycerine plus all other agents available in this field, would justifiably be designated "intractable." There is a problem of semantics here, in that the word "intractable" carries with it a sense of finality, permanency and even ultimate total failure. The Latin derivation would indicate

that it means unmanageable, but even more, not capable of being controlled. Therefore from a semantic point of view it would enhance our cardiologic literature to employ the term "refractory angina." Thus in our discussions of therapy for this difficult problem all would understand that there is not yet an element of hopelessness and that radioactive iodine therapy or one of the various surgical procedures may turn the tide back from refractoriness to more satisfactory control.

In facing up to the question as to whether any given patient is experiencing one of these closely related syndromes the clinician is confronted with two very vital questions. First, is it really anginal pain? How many pathetic people have been asked to live under the sword of Damocles—of possessing coronary artery disease when they really had one of the hosts of conditions mimicking and simulating this common national ailment? Physicians are becoming more astute and more adept at diagnosing such entities as the Tietze's syndrome, Davis syndrome of radicular pain, Mendelowitz syndrome of myositis of the pectoralis muscle, atypical pain of neurocirculatory asthenia, high splenic flexure syndrome, xiphoid-algia, various musculoskeletal disorders of the anterior chest wall, gall bladder disease and diaphragmatic hiatus hernia. It becomes quite apparent that the pure cardiologist can only approach this sub-speciality through adequate intellectual orientation in the field of internal medicine.

The second vital question the clinician must ask himself in confronting these various closely allied syndromes of angina pectoris is most pertinent if he is to expect any results from therapy. Are there any extracardiac conditions intensifying the pain and thwarting efforts to abolish it? Uncorrected anemia, uncontrolled hyperthyroidism, profound emotional disturbances, extreme obesity, severe diastolic hypertension, unrecognized or uncontrolled diabetes mellitus certainly will hamper the efforts of the physician to control the more frequently and more easily developing attacks of angina pain. It is trite to state that undoubtedly the finest cardiologists are such because they are basically fine clinicians with a broad view of the entire vista of medicine.

Pathologic Implications

Prior to embarking on methods of management of these anginal syndromes one cannot

help but establish orientation with the pathologic significance of these closely related entities. Assuming that the patient is really having increasingly frequent anginal pain, more easily produced anginal pain, pain less easily controlled by nitroglycerine, pain occurring at rest—often at night, and being very certain that no extracardiac causes are jeopardizing coronary flow and worsening the situation—then what is going on, pathologically, in the heart?

A number of pathologic situations may be responsible for this crescendo type of experience in the life of the patient with angina pectoris. They are as follows:

1. The patient may well have had an occlusion without infarction. In this situation a fairly good-sized branch of the coronary arterial tree has been occluded but the collateral and supplemental circulation was adequate to prevent a definite area of infarction. True, there may well have been miliary areas of infarction, certainly a vessel was occluded and pain ensued, but additional circulation was available to prevent necrosis of tissue in a fairly widespread area.

2. A second pathologic comment may be made—and this applies most significantly to those patients with angina decubitus or nocturnal angina. This pattern of repetitive angina, primarily occurring at rest and at night, often relieved by sitting up, may well represent occult, subtle or sneaky cardiac decompensation. Not infrequently an injection of a mercurial diuretic may be exceedingly dramatic in relieving the frequency of the pain because the coronary insufficiency was actually secondary to myocardial insufficiency.

3. The pattern of increasingly frequent angina, more easily produced and possessing many of the other elements of these various syndromes previously described, may represent an impending myocardial infarction. Herein is the vital challenge to the physician to step in and provide all means at his disposal to prevent what seems to be a close and imminent reality.

4. Finally, one may well rest on the fact that the patient has so much severe, diffuse coronary artery disease that he is really in a state of intense chronic coronary insufficiency at all times. This would suggest that there have been multiple occlusive episodes in the past of minor or even major branches and subendocardial ischemia is a real and vital problem to this individual.

Therapeutic Approaches

The practical and pragmatic aspects of this presentation involve what can be done to reduce the frequency and the intensity of the anginal attacks and prevent an ultimate myocardial infarction. One hopes to develop additional intercoronary anastomoses and the approach must be quite basic and medical in its aspects.

1. Rest is vital. Bed rest must be carried out with the head and shoulders of the patient elevated. In this position venous return to the right heart is lessened and cardiac work is reduced. Also it is the common experience of these patients to find that sitting up on the edge of the bed, standing up by the side of the bed or sitting in a chair will relieve the nocturnal anginal pain.

2. Anginal patients desperately need sedation. They need sedation to reduce their response to life's experiences and vicissitudes and to reduce their apprehension about having heart disease. Practically no anatomical area of the body triggers off more anxiety than knowing that one has a cardiovascular problem. Equanil, Compazine, or Librium can be used to reduce the emotional component in the patient's make-up.

3. A sojourn in an oxygen tent is often helpful in reducing frequency and intensity of the anginal pain. It may be that its value lies in reducing subtle cardiac decompensation.

4. Weight reduction is vital. Attacks of angina pectoris in the obese patient are often sharply decreased in frequency by proper weight reduction. Reduction in weight reduces cardiac work. This may be accomplished by caloric restriction, by eating more frequent small meals but also by reducing the fat content of the diet so that only 25 to 30% of the caloric intake comes from fats. Also the highest percentage of this fat should be in the polyunsaturated form. Frequent small meals, meals so designed as to avoid postprandial lipemia, often reduce this proclivity to the syndrome of postprandial angina. Patients should be advised to avoid exertion and emotional excitement immediately after meals.

5. Nitroglycerine in hypodermic tablet form, under the tongue and employing the smallest dose that will do the job, is the bellwether that leads all therapies in ameliorating this condition. A specific number of nitroglycerine tablets are left by the side of the bed for immediate use in the prevention or relief of pain. The amount

employed in 24 hours is carefully recorded and the results of treatment can be gauged by noting the reduction in the needs for nitroglycerine.

6. Should severe diastolic hypertension be a contributing factor in the continuance of pain, various acceptable classic methods for reduction of blood pressure must be employed. A sane axiom in this regard should be mentioned. Blood pressure should never be lowered too fast or too far so that coronary thrombotic or cerebral thrombotic episodes are invited thereby.

7. Insertion of an aminophylline suppository or the use of a rectal theophylline retention enema at hour of sleep may often be helpful in preventing nocturnal anginal pain.

8. The medical profession has available an abundance of so-called long-acting, chronic coronary dilators. Many of these are not terribly successful, not noteworthy for producing great results but still not completely without value. A list of these would be impractical, but many of them embody the drug pentaerythritol tetranitrate. A new coronary artery dilator called Isordil has made its debut and whether it stands up under the test of time will be noted. To enhance efficiency most of these preparations must be taken on an empty stomach.

9. In the hands of this author the use of nitroglycerine in ointment form (Nitrol Ointment) rubbed into the forearm or precordium three or four times a day has been most successful and most helpful. The dosage is started at a low level and slowly increased to higher figures. Certainly we know that the drug is absorbed for if the dose is too high a typical nitrite headache will ensue. The rationale for the use of nitroglycerine or nitroglycerine in ointment form is based on the fact that animal experimentation after coronary artery ligation has shown that nitroglycerine is really the only reliable agent capable of developing intercoronary anastomoses.

10. It is strongly suggested that anticoagulant therapy be given in an effort to prevent an impending infarction, should this be suspected from clinical data. Most physicians would feel this wise in the patient at bed rest. Certainly when both the frequency and severity of the anginal episodes are increasing, anticoagulants may be of value in preventing coronary thrombosis and myocardial infarction. We often fail

to remember that coronary artery disease is both a sclerotic as well as an occlusive disease.

11. In the presence of angina decubitus and nocturnal angina where occult or even overt heart failure may be involved all routine classical measures to control cardiac decompensation should be employed. These involve mainly sodium restriction, digitalization, oral and mercurial diuretics. As mentioned previously the effect on the pain pattern by one injection of a mercurial diuretic may be most helpful in determining whether subtle cardiac decompensation is present.

12. Some mention should be made concerning the wisdom of avoiding narcotic addiction in these patients. The physician can simply give up and allow the patient to take narcotics ad lib, or seriously and conscientiously enter into a total program to improve myocardial blood flow and oxygenation. It has not been the author's experience to need to give up the ghost and allow the patient to become a hopeless narcotic addict.

13. Additional support has been added to the therapeutic armamentarium of refractory angina. The monoamine oxidase inhibitors have been most helpful in controlling frequency of anginal pain. The author's experience has been principally with Niamid employing 25 mg three times a day. This agent, along with the totality of the rest of the program, has frequently been the added factor promoting success. There are a number of preparations of this type and fortunately the dosage required to relieve anginal pain is much lower than the dosage employed by the psychiatrist for depressive states.

14. Further comments about diet are in order. We accept the entity known as postprandial angina. We appreciate that there is a postprandial lipemic tide. We appreciate that lipemia invites sludging, increased cohesiveness of cells and increased clottability of blood. Thus one need not become embroiled in the complex argument as to whether lipids play a part in inviting atherosclerosis or their restriction in slowing down its progression. But one can support the low fat and low cholesterol diet because it does aid in reducing weight and does combat these unfavorable features mentioned above.

15. In about five percent of patients with angina pectoris the pain may be so refractory that radioactive iodine therapy must be considered. Some degree of improvement is to be expected in approximately 75% of the group. Ideal

candidates for this type of treatment are those with severe angina, angina of considerable duration and angina which has failed to respond to the various conventional therapies mentioned above. In addition those who have congestive heart failure are particularly suitable for this program. Patients with rapidly progressive coronary artery disease, those who have had a myocardial infarction within six months and those with malignant hypertension are not favorable candidates for radioactive iodine. Improvement usually parallels the degree of hypothyroidism produced and the patient receiving this therapy should be aware of this. Indeed, at times, the severity of myxedema has to be controlled by thyroid therapy.

16. Failing to relieve the frequent, intense, violent and morale-destroying pain with the various conventional measures outlined above, one may then seriously consider entering into one of the various surgical procedures available today. Cardiovascular surgeons appreciate that not one of the seven or eight procedures in vogue really meets the total need of the problem from a pathologic point of view. The physician should seek out that operative procedure with the lowest risk, the lowest mortality, the easiest aspects of accomplishments and with a reasonably good percentage of relief. Granted this is asking a good deal of the surgeon, but these patients are subject to sudden death on a mechanism basis-reflex cardiac standstill or ventricular fibrillation.

17. Finally, one area has been ignored in the presentation because of the controversial and

thorny nature of the problem. This involves the question of smoking. The effect of smoking on angina is not clearly understood, although there is strong and suggestive evidence that in some people the work of the heart is increased. In the author's opinion, cessation of smoking is probably the ideal. In some people the emotional strain of stopping, the increase in the appetite and weight resulting thereby, is so deleterious and unfavorable that moderation must, at times, be permitted. Patients should be told that coronary artery disease is two and one-half times more frequent in the smoker, that anginal pain may be lessened by total abstinence, that moderation soon gives way to the old pattern and that the wisest policy would be cessation of the habit.

Summary

Medical terminology has become encumbered with multiple terms having overlapping meanings clinically, overlapping significance pathologically, but perhaps great uniformity in therapeutic management. The various closely-allied syndromes of angina pectoris have been mentioned and various therapeutic approaches discussed. The patient with angina desperately wants help. He wants direction, guidance and explanation. He may have trouble cooperating in the areas of diet, weight reduction and nicotine, but in general, his pain becomes of such frightening import to him that he is willing to ultimately get on the bandwagon of total cooperation. ◀

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Cool Babies

A new method of saving infant lives was reported recently at the UCLA Medical School, according to *Insider's Newsletter*. Visiting specialist Dr. Bjorn Wertin of Stockholm said that physicians in many Scandinavian medical centers are treating newborn babies who have difficulty in breathing by putting them in cool environments to lower their body temperatures 5 to 10 degrees. Reason: As the body is cooled, all life processes slow down and the infant has less need for oxygen. When this occurs, the breathing mechanism has less strain and the child can make an easier adjustment to life outside the uterus. Interesting Note: Statistics show that the infant mortality rate in Scandinavian countries is the lowest in the world.—*Journal of the Mississippi State Medical Assn.*, March, 1961.

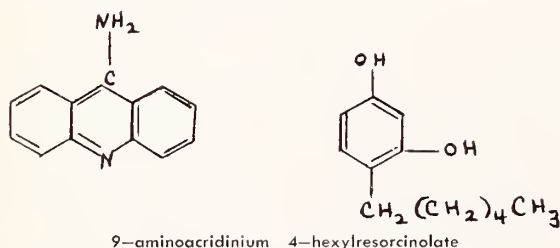
Akrinol, a New Topical Anti-Infective Agent

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IN SPITE OF the wide variety of antibiotic and chemotherapeutic agents currently available to us, there are still numerous dermatologic conditions of microbial etiology for which there is no uniformly satisfactory treatment. Therefore, the development of a new antiinfective medication which proves helpful in some of these indications is always gratifying. We have recently carried out a clinical study on Akrinol, which appears to be such an agent.

Akrinol is a chemical combination of 9-aminoacridinium and 4-hexylresorcinolate. The group of acridines, of which 9-aminoacridine is a member, has long been known to exert a bactericidal or bacteriostatic effect upon a variety of organisms.¹ Hexylresorcinol has been used as a urinary antiseptic since 1924,² and as an anthelmintic since 1931;³ it has also been described as an efficient antiseptic when applied locally.¹



Materials and Methods

We have studied Akrinol as the sole medication in 65 patients with tinea pedis; in conjunction with oral administration of griseofulvin

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Akrinol for this study was furnished through the courtesy of G. Kenneth Hawkins, M.D., Department of Clinical Investigation, Schering Corp., Bloomfield, N. J.

(Fulvicin) in 100 patients with tinea pedis, and as the sole medication in 27 patients with tinea versicolor (pityriasis versicolor). Diagnosis was confirmed by positive microscopic examination and/or culture in all cases.

Eighteen of the 65 tinea pedis patients receiving no oral medication were instructed to apply Akrinol to one foot and zincundate, triacetin or Asterol to the other foot, for control purposes. Twenty-five of the 100 tinea pedis patients receiving Akrinol and concomitant oral therapy with griseofulvin, 250 mg q.i.d., were instructed to apply Akrinol to only one foot and nothing to the other. In all cases Akrinol was applied in the form of powder or aerosol spray upon arising and in the form of ointment before retiring. Patients were advised not to use rubber shoes or woolen or nylon footwear.

The 27 tinea versicolor patients received no other medication, with the exception of tincture of green soap. For control purposes, 10 of these patients were instructed to apply Akrinol to one-half of the affected body surface (e.g., front or back of body) and one of three other medications (sodium thiosulfate and vinegar, ammoniated mercury, or half-strength Whitfield's ointment) to the other half. Patients were instructed to apply Akrinol in the aerosol spray form upon arising and in the ointment form before retiring.

Tinea pedis was selected for this study because it appears to be the only type of ringworm which does not respond satisfactorily in all cases to oral therapy with griseofulvin;⁴ tinea versicolor was included because therapy with the hitherto available medications, although generally effective, is quite lengthy.

TINEA PEDIS *Trichophyton rubrum*



Figure 1
Tinea pedis after three months griseofulvin,
250 mg q.i.d.



Figure 2
Two months after addition of Akrinol
to therapeutic regimen.

THIS 31-YEAR-OLD male had severe tinea pedis of 13 years' duration as well as tinea manum, tinea cruris and onychomycosis of fingernails. On griseofulvin, 250 mg q.i.d., crural area cleared in three weeks, palms in two months and fingernails in three months; however, feet failed to show satisfactory improvement. After addition of Akrinol to the griseofulvin regimen, feet cleared within three months.

Results in Tinea Pedis

Of the 65 tinea pedis patients receiving Akrinol only, for periods ranging from one to six months, 10 had apparent clinical cures, as reflected by complete involution of lesions and negative KOH slides and cultures; 47 experienced significant improvement, as shown by progressive regression of lesions and decrease in itching and five remained unchanged; the medication had to be withdrawn in three cases as a result of a localized dermatitis venenata. In the 18 cases in which Akrinol was used on one foot and zincundate, triacetin or Asterol on the other, it proved as good as or superior to these agents. In contrast to the other three medications, which produced local irritation in several cases, the topical application of Akrinol was well tolerated locally and produced no systemic effects.

Of the 100 patients receiving Akrinol topically and griseofulvin, 250 mg q.i.d., orally for periods ranging from three weeks to six months, 63 were clinically cured, 29 are improving, five have shown no change and three exhibited local irritation to Akrinol, leading to aggravation of the condition. In the 25 patients who were instructed to apply Akrinol to one foot and nothing to the other, the foot medicated with Akrinol showed substantially greater improvement after the first

two weeks, and at the end of the third week all patients in this group were applying the medication to both feet. It is interesting to note that 23 of the 91 patients who were clinically cured or are improving on the combined regimen of griseofulvin and Akrinol had previously failed to show any improvement on griseofulvin alone.

Results in Tinea Versicolor

The results obtained with Akrinol in tinea versicolor were dramatic. All 27 patients became asymptomatic, that is, free of lesions, within three days; KOH slides and cultures became negative for *Malassezia furfur* within three weeks. Despite these rapid results, treatment was continued for six weeks in the hope of preventing recurrences.

The 10 patients who were instructed initially to apply Akrinol to one-half the affected body surface and another medication to the other half were all switched to Akrinol entirely after three days, in view of the excellent response produced by this agent. There have been no recurrences in this group of patients, followed for up to one year. In our experience the recurrence rate with other topical agents used in tinea versicolor has been higher than 50% within one year.

TINEA VERSICOLOR

Malassezia furfur



Figure 3
Before treatment.

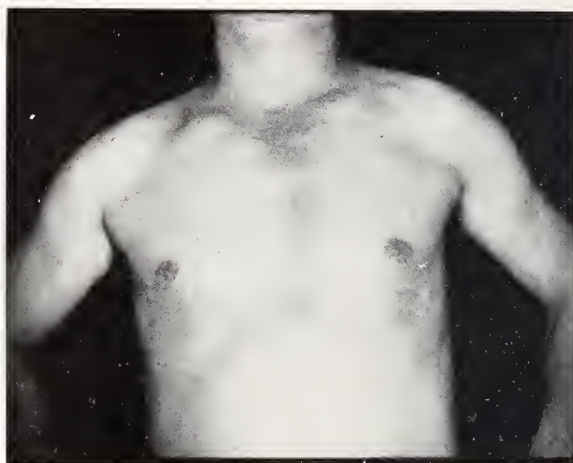


Figure 4
After 5 days of Akrinol therapy.

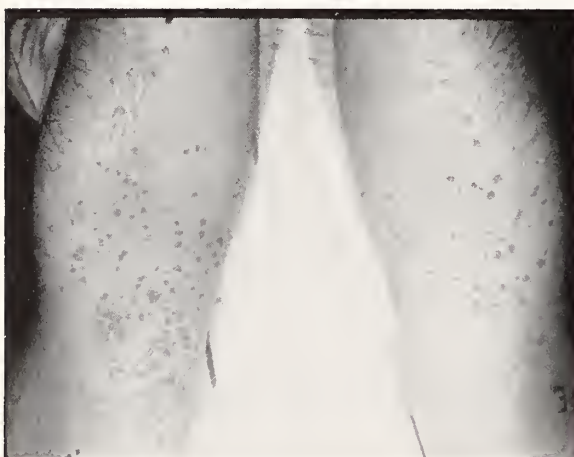


Figure 5
Before treatment.

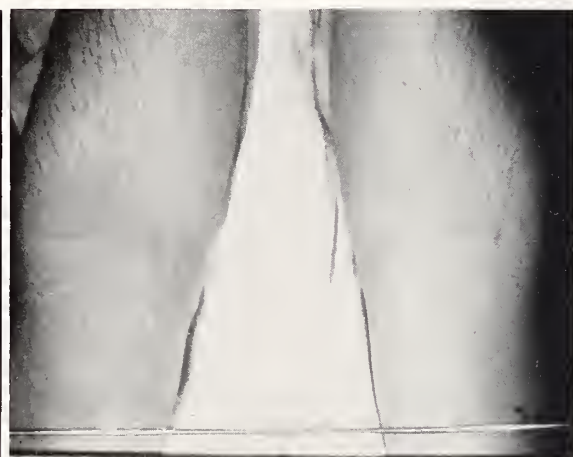


Figure 6
After 3 days of Akrinol therapy.

Discussion

Results obtained in our study suggest that Akrinol is a useful adjunct when used concomitantly with systemic griseofulvin therapy in resistant cases of tinea pedis. This topical agent appears capable of accelerating improvement in moderately severe cases, and of achieving cures when employed alone in milder cases. Its beneficial effects in tinea pedis appear to be due to its marked antifungal activity and drying action.

In view of the excellent results Akrinol produces in tinea versicolor, for which there had been no truly satisfactory treatment, we consider it the drug of choice in this condition.

The exceptionally low incidence of local irritation observed with Akrinol and the total absence

of systemic side effects, probably due to lack of systemic absorption, make it one of the safer topical anti-infective agents.

We have also used Akrinol in a number of bacterial and eczematoid dermatoses and, as an adjunct, in stasis ulcers, but found it of little value in these conditions. We were unable to reproduce the encouraging results in nonfungal dermatoses reported by Grayson and Shair.⁵

Summary and Conclusions

1. Akrinol was used in the form of ointment, aerosol spray and powder, in 165 tinea pedis patients (as the sole medication in 65, and as an adjunct to systemic griseofulvin therapy in 100) and in 27 tinea versicolor cases.

Results in Tinea Pedis Akrinol Only

No. of Patients	Sex	Age Range	Average Duration of Therapy	Results	Side Effects
65	M-41 F-24	3-74 yrs.	4 wks.—6 mos. (average—3 mos.)	10—apparently cured (KOH negative) 57—much improved 5—no change 3—worse	No systemic side effects. 3 cases of localized dermatitis venenata or aggravation of local disease.
<i>Akrinol and Fulvicin</i>					
100	M-63 F-37	9-79 yrs.	3 wks.—6 mos. (average—10 wks.)	63—cured (KOH and culture negative) 45 <i>T. rubrum</i> 12 <i>T. mentagrophytes</i> 6 <i>E. floccosum</i> 29—much improved (still residual disease) 17 <i>T. rubrum</i> 9 <i>T. mentagrophytes</i> 3 <i>E. floccosum</i> 5—no change 3 <i>T. rubrum</i> 1 <i>T. mentagrophytes</i> 1 <i>E. floccosum</i> 3—worse 2 <i>T. rubrum</i> 1 <i>T. mentagrophytes</i>	No systemic side effects. 3 cases of local sensitivity.

TABLE I

Results in Tinea Versicolor

No. of Patients	Sex	Age Range	Average Duration of Therapy	Results	Side Effects
27	M-16 F-11	3-67 yrs.	6 wks.	Excellent in all cases—culture negative.	None

TABLE II

2. When used alone, Akrinol proved as effective as or superior to other available topical agents in the treatment of tinea pedis; when used as an adjunct to systemic griseofulvin therapy, this agent produced improvement in cases which had previously failed to respond to griseofulvin alone, and accelerated improvement in others.

3. Dramatic results were obtained with Akrinol in all tinea versicolor patients studied; involution of lesions occurred within three days and apparent cure within three weeks.

4. Akrinol exhibited an exceptionally low index of sensitization, with only six of 192 patients developing local irritation.

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Present Status of Radioisotopes In Clinical Medicine

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Gary

RADIOISOTOPES ARE ISOTOPES which give off radioactive emissions. Atoms which have same atomic numbers but different atomic weights are called isotopes (from the Greek *isos* and *topos*, meaning the "same place," i.e., the same place in the periodic table).¹ Isotopes of the same element always have identical chemical properties. Their difference in weight often conveys an instability to some isotopes. These unstable isotopes break down at a characteristic rate, becoming radioactive by releasing alpha, beta or gamma emissions or combinations. More than 1,200 isotopes have been discovered,² iodine alone having approximately 21 isotopes.

In the recent decade influence of radioisotopes on medicine has become so great that every modern physician must have a basic knowledge of radioisotopes and their clinical uses. It is the purpose of this presentation to give an up-to-date review on this subject, limited to the diagnostic and therapeutic uses of commonly-applied radioisotopes.

Radioisotopes in Diagnosis

1. *Thyroid diseases.* Diagnosis of thyroid disease depends on evaluation of the functions of the thyroid. Iodine-131 (I-131) is most often used to test thyroid functions. The usual method is to give orally, on a fasting stomach, a simple solution of I-131 and measure the thyroid uptake of the radioactive iodine in a certain unit of time, usually 24 hours. In general, the I-131 uptake at 24 hours is thought to represent a hyperthyroid state if it is in excess of 50% of the administered dose; to be in the normal range if between 15-45%; and in hypothyroid range, 10% or less.³ It has been estimated that the accuracy

of the I-131 uptake in evaluating thyroid function is 90-95%. This compares favorably with a general accuracy of about 65% for B.M.R. test and 85-90% for the conventional protein-bound-iodine (P.B.I.) determination.^{3,4} The uptake test may be combined with excretion tests which measure the quantity of I-131 excreted in saliva, urine or feces. In hyperthyroidism less I-131 is available for excretion and in hypothyroidism more is available. Thyroid clearance rate may be measured in a modified setup. Radioactive P.B.I. (PBI-131) and PBI conversion ratio (ratio of PBI-131 to total serum I-131) can also be determined. This furnishes an additional method for testing thyroid functions by using I-131 in form of RISA (radioactive iodine serum albumin).

Recently the so-called "T-3 red cell uptake" test was developed in which the patient's red blood cells are incubated with I-131 labeled L-triiodothyronine and the percent red blood cells uptake is calculated. This in-vitro test is suitable for use in children, and in following the course of patients being treated with thyroid hormone without stopping the medication. In addition, suppression tests following a dose of triiodothyronine may be used to clarify equivocal findings of borderline conditions. Administration of thyroid-stimulating hormone (TSH) is useful for distinguishing myxedema secondary to panhypopituitarism from myxedema due to intrinsic thyroid disease.⁵ Scintillation scanning of thyroid following the administration of I-131 aids in localizing a toxic nodule or a non-functioning area in the thyroid which may represent a neoplasm. Malignant neoplasms have been found in 30% of cases which showed non-functioning or hypofunctioning areas on scintillation scanning.^{6,7,8}

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2. *Plasma or blood volume.* The plasma or blood volume is generally determined by injecting RISA into circulation. After thorough mixing has occurred, a blood sample is withdrawn and the radioactivity of a portion of plasma or heparinized whole blood is measured. Using a dilution formula, the plasma or blood volume is then calculated. The procedure is accurate and completely safe even for many repeat examinations. Radioactive chromium (Cr-51) and radioactive phosphorus (P-32) are less frequently used for this procedure.

Anemias due to Malabsorption

3. *Pernicious anemia and megaloblastic anemia due to malabsorption.* These can be diagnosed and differentiated by performing a Schilling test.⁹ In the test procedure the patient is given orally a dose of radioactive cobalt (Co-60) labeled vitamin B-12. A 24-hour urine specimen is collected and the radioactivity of the specimen measured. Should the specimen contain over 8-12% of the administered dose (in terms of radioactivity), the patient does not have pernicious anemia or malabsorption. If, on the other hand, the urinary radioactivity is much lower, in the order of 3.0%, the patient probably has pernicious anemia due to deficiency of intrinsic factor or megaloblastic anemia due to malabsorption.

To differentiate between these two conditions the patient is then given intrinsic factor orally together with Co-60 labeled vitamin B-12. A normal urinary output of the Co-60 would then mean pernicious anemia while a persistent low urinary output would indicate malabsorption. Several modifications of the Schilling test have been employed. One determines the fecal excretion of Co-60 B-12 in patients with pernicious anemia following a standard oral dose of Co-60 B-12 with and without added intrinsic factor. This measures the nonabsorbed B-12 containing Co-60.

In another, a flushing dose of 1000 mcg of nonradioactive B-12 is given intramuscularly after the oral administration of Co-60 B-12. If the patient absorbs more of the oral Co-60 labeled B-12, he will excrete more in the urine when the large flushing dose is given. If little or none of the Co-60 B-12 is absorbed, the urine will contain very little or none of the Co-60 B-12.

A third test is based upon the uptake of radio-

activity by the liver when the patient is given a standard oral dose of Co-60 B-12 with or without intrinsic factor added. The Schilling test has proved to be reliable diagnostic procedure by which pernicious anemia can be detected even in patients who are in remission or have been treated.

Determining Malabsorption Syndrome

4. *Malabsorption syndrome.* This may be determined by giving the patient an oral dose of I-131 labeled oleic acid or radioactive iodotriolein. In unit time blood samples are withdrawn from the patient for determination of their radioactivity. Low radioactivity would indicate malabsorption. This procedure has importance in the evaluation of gastrointestinal and pancreatic functions.

5. *Hemolytic anemias.* In hemolytic anemias survival time of red blood cells and red cell mass can be determined by tagging a red cell sample with Cr-51. The sample is then injected into the patient's circulation and at intervals blood samples are withdrawn from the patient for measurement of their radioactivity. Normal values for half-time survival of red cells ($T_{1/2}$) have been reported ranging from 22 to 32 days.¹⁰⁻¹⁹ The variation depends on the method used for determination of the 100% value. If a 24-hour postinjection level is selected as the 100% value, normal limits would be nearer the lower half of the range. Shortened survival times have been seen in a variety of hemolytic conditions, including hereditary spherocytic anemia, sickle cell anemia, thalassemia, paroxysmal nocturnal hemoglobinuria, hemoglobin C disease and acquired hemolytic anemia.²⁰

Shortened survival time may also be seen in hepatic disease, pernicious anemia and malignant neoplasia.²⁰ The Cr-51 technic has been used to detect presence of antibodies which could not be demonstrated by means of the usual serologic methods.²⁰ In sequestration studies, counting technics are applied to the body surface, especially over liver and spleen, for determination of the sites and concentration of radioactivity in the various internal organs after intravenous injection of Cr-51 labeled red blood cells.

Test results provide important information with regard to the sites and degree of hemolysis or red cell sequestration. Results are expressed diversely as spleen : liver ratio, or spleen or liver : precordium ratios. Elevated spleen : precordium

ratios, implying excess splenic sequestration of red cells, have been observed in hereditary spherocytic anemia, thalassemia, acquired hemolytic anemia, hemoglobin C disease and various conditions associated with hypersplenism. Pronounced elevation in the liver: precordium ratio has been observed in sickle cell anemia and other conditions which cause agglutination of red cells in the patient's body. Attempts have been made to predict value of splenectomy by means of establishing a splenic sequestration index (S.I.), calculated by means of subtracting the values for spleen: precordium ratio, at the point when 50% of the original radioactivity blood level had disappeared, from the ratio at "zero time."¹⁴ Data obtained from the counting technics on the body surface seem to be more consistent clinically when negative evidence of splenic sequestration is observed than when positive results are obtained.²¹

Use of Radioactive Iron

6. *Iron metabolism and iron deficiency anemia.* Radioactive iron (Fe-59) is used to study iron absorption and utilization, the localization of iron in tissues and the determinations of plasma iron clearance and turnover. Rate and site of hemoglobin synthesis can also be determined. This isotope offers great value in studying polycythemia, leukemias and anemias having abnormal iron metabolism.^{22,23} Iron turnover is usually increased in untreated polycythemia, pernicious anemia in relapse, chronic leukemia, hemolytic or iron deficiency anemia and erythroid hyperplasia.²² It is decreased in erythroid hypoplasia, marrow arrest at a stage prior to the incorporation of iron into the red cells or aplastic anemias.²⁴

By studying the plasma iron turnover together with in-vivo body counting, it is easy to differentiate splenomegaly with extramedullary hematopoiesis from splenomegaly with active red cell destruction.^{22,25} In case of iron deficiency anemia due to gastrointestinal hemorrhage the degree of blood loss can be quantitated by measuring the radioactivity in feces after intravenous administration of Cr-51.^{26,27,28,29} Normally there is little or no fecal excretion of this isotope when it is administered intravenously. Fe-59 may be used in a similar manner.

7. *Liver and kidney functions.* Rose Bengal dye labeled with I-131 has been used to test hepatocellular function.^{30,31} A poorly-function-

ing liver shows slow and reduced uptake, while biliary obstruction often results in retention of the radioactive dye. The procedure can be used to detect non-functioning areas in the liver produced by tumefaction or necrosis. Use of I-131 in Diodrast has been developed for qualitative and quantitative analysis of renal functions.³²

Tumor Detection, Localization

8. *Tumor detection and localization.* RISA and P-32 have been used for detection and localization of brain tumors with reasonable accuracy.^{33,34,35,36,37} The RISA crosses the brain barrier when tumor is present. Then the tumor is localized in the brain by P-32 which is taken into the tumor because of increased metabolic rate of the neoplasm. P-32 has been successfully used for identification of malignant tumors in breast,³² bowel and cervix,³⁸ as well as for localization of metastatic tumors. The same isotope has also been used for diagnosis of intra-ocular tumors, such as melanomas which take up P-32 to a greater degree than normal ocular tissues.² In addition, arsenic-74, copper-64 manganese-52 and potassium-42 have been used to localize brain tumors.³⁹

9. *Status of circulation and cardiac output.* Degree of block in obstructive arterial disease can be determined by RISA. The same preparation can be used to measure cardiac output as shown by Pritchard et al.^{40,41} and Ketyer, et al.⁴² RISA, and recently, krypton-85 have been used to measure cerebral blood flow.⁴³ I-131 labeled sodium and methylglucamine diatrizoate have been used for circulation studies in congenital heart diseases.⁴⁴ Other applications include determinations of the effectiveness of vascular shunts and vascular grafts, revascularization of pedicle skin grafts, venous stasis, circulation times, etc.⁶ Strontium-86m and recently EDTA-Cr-51 are used in radiocardiography and determination of myocardial blood flow and intramuscular clearance.⁴⁵

10. *Determination of body water and electrolytes.* Total body water may be measured using radioactive hydrogen (H-3).^{5,46} Radioactive sodium (Na-22 and Na-24) and radioactive potassium (K-42) are employed to determine the total exchangeable sodium or potassium in the body.^{47,48} Radioactive bromine (Br-82), and less commonly, radioactive chlorine (Cl-36) have been used for chloride-space studies.⁵ Sodium, potassium and chloride spaces can be

determined concomitantly with the mentioned isotopes by a pulse-height analyzer.^{5,49}

11. *Miscellaneous applications.* Radioactive carbon (C-14) has been used in the study of metabolic disorders involving sugar, protein, lipid, cholesterol and pigment synthesis.⁴⁶ Isotopes also have applications in radiocardiogram for study of heart diseases.⁵⁰ In this procedure an isotope is injected intravenously and the counting rates are mapped as the isotope passes through the heart. Continuous recording of the changing counts over the heart will assume certain unique patterns in the presence of cardiac diseases.⁵ So-called "autoradiography" for study of the pattern of isotope uptake in tissues can also be performed easily through the use of radioisotopes.⁵

Radioisotopes in Therapy

1. *Thyroid diseases.* I-131 has been widely used for treatment of hyperthyroidism. The following principles are generally observed: (1) I-131 is generally believed to be the treatment of choice for diffuse thyrotoxicosis if the patient's age is 40 or older. (2) Regardless of age, all patients with recurrent hyperthyroidism following surgical removal of the gland are suitable candidates for I-131 treatment. (3) All poor surgical risks, regardless of age, are suitable candidates and this is particularly true of cardiac patients. This holds true for toxic nodular goiter, although the dosage required is greater and the response is not as prompt as in case of diffuse thyrotoxicosis. (4) Patients with progressive exophthalmos may either regress or become stationary following the I-131 treatment, but the exophthalmos usually progresses following surgical removal of the gland. (5) Contraindications to the I-131 treatment include pregnancy, lactation and possibly young age and solitary nodular goiter which is resectable surgically.

Patients with severe hyperthyroidism should receive preparation for I-131 treatment with antithyroid drugs to avoid thyroid crisis or acute congestive heart failure. Patients receiving I-131 may not show appreciable benefits for two months, and the full benefit may not be apparent for three and occasionally for four months. For diffuse thyrotoxicosis, 50 to 80% of patients will be returned to a euthyroid status within a three-month period and following one or two I-131 treatments. An additional 10 to

25% becomes euthyroid within an additional three-month period, and approximately 95% of all isotope-treated patients become euthyroid within a nine-month period.^{42,51} The recurrence rate has been small and the incidence of permanent hypothyroidism is less than five to 10%. Hypothyroidism occurs in a few months to six years following the treatment. In a recent report,⁵² about 40% of 436 patients of toxic nodular goiter and 50% of 1,167 patients with diffuse thyrotoxicosis were cured with a single dose of I-131. Ninety-two percent of the patients with toxic nodular goiter were eventually cured with one or more doses of I-131.

For thyroid carcinoma I-131 should be considered when the tumor is unresectable or there are multiple foci and the tumor has a high iodine uptake. Prior to the treatment, administration of propylthiouracil or thyroid-stimulating hormone or both may be used to increase the I-131 uptake. Results may not be encouraging, but palliation can be obtained in approximately 10% of patients who otherwise could not be treated surgically.

Use In Blood Diseases

2. *Blood diseases.* P-32 in small doses have become a standard treatment in polycythemia vera. An initial dose of four millicuries can produce a remission in the average patient for a period of anywhere between six months to two years.⁴² It generally takes two months for the P-32 to reach its full effect. Its advantage over phlebotomy is that the isotope gives a more lasting effect and does not cause over-production of platelets which often induces thrombosis. P-32 has been used with great success in chronic lymphocytic leukemia as well as in chronic myelogenous leukemia, especially when chemotherapeutic agents become ineffective or contraindicated. Radioactive colloidal gold (Au-198) also has value in the treatment of chronic leukemias.⁵ Occasional use of I-131 or P-32 in case of multiple myeloma may bring relief of pain to the patient.

3. *Cardiac and vascular diseases.* Approximately 90% of patients with intractable angina pectoris and 50% of patients with intractable congestive heart failure can be made comfortable by the administration of a small dose of I-131.⁴² Selected cases of intermittent claudication can also be benefited by the isotope.⁵ The isotope produces a hypometabolic state in selected pa-

tients whose I-131 uptake is in the middle or upper euthyroid range.

4. *Effusions.* Colloidal Au-198 and radioactive colloidal chromic phosphate can emit effective beta radiation. They have established value in the treatment of intractable effusions, especially those due to metastatic malignancy. Treatment is most effective when the accumulation of fluid in peritoneal or pleural cavity is rapid, and when paracenteses or thoracenteses become necessary at shorter intervals.⁵ It is best to use the radioactive colloid as soon as an unremitting effusion pattern is established, so that excessive adhesions resulting from frequent tapping will not prevent the uniform distribution of the solution throughout the serosal space.⁵ More than 50% of cases show good response lasting from several weeks to several years.⁴² Silver-coated Au-198⁵³ and P-32 may be used for the same purpose, but is less popular.

Therapy

5. *Malignant tumors.* Therapeutic uses of radium (Ra-226) and radon (Rn-222) are well known to the medical profession and will not be discussed in this presentation. Probably one of the most significant advances in cancer treatment is cobalt-60 teletherapy which offers supervoltage radiation equivalent to two to three million-volt x-ray therapy. A cobalt machine offers a number of advantages over high voltage x-ray therapy in the treatment of cancer.⁵⁴ Among the advantages Co-60 produces greater penetration, less skin reaction, less radiation sickness and less absorption by bone and cartilage. A cobalt unit is more compact in construction and less complicated in electric circuitry than an x-ray machine.⁵

Radioactive iridium (Ir-192) and radioactive cesium (Cs-137) may also be used for teletherapy with certain advantages and disadvantages over the Co-60. In the so-called external-mold therapy, Co-60 and radioactive tantalum (Ta-182) are used for effective gamma radiation. Radioactive strontium (Sr-90) and radioactive yttrium (Y-90) are used for effective beta radiation. In interstitial therapy, Au-198, Co-60 and silver-coated Au-198 and Ir-192 are commonly used. They may be made in forms of solutions, tubes, wires, threads, capsules, needles or seeds.

In terms of specific tumors, injection or insertion of Au-198 has an established value in

treatment of carcinoma of the prostate. The same isotope in form of solution, balloon or capsules has been used with success in the treatment of urinary bladder, bronchogenic and pelvic carcinomas.⁵ Na-24, Br-82, Co-60 and Ir-192 may be used for the same purpose but are less popular. Co-60 teletherapy is a very satisfactory modality for treating carcinoma of breasts.⁵⁵ Co-60 has also been used with success in the treatment of carcinoma of esophagus and carcinoma of cervix and vagina. P-32 has been used in the treatment of malignant lymphoma.

6. *Eye lesions.* Sr-90 in form of superficial irradiation (beta radiation) is most useful in the treatment of eye lesions, such as pterygiums, corneal ulcers and vascularization and other ocular lesions which are greatly aided by beta radiation.^{5,42} The same isotope gives encouraging results in the treatment of melanomas⁵ and retinoblastomas.²

Hazards and Future of Radioisotopes

Main hazards in the use of radioisotopes are those arising from radiation. Tracer doses used in diagnostic procedures are usually so small that they are perfectly safe. Therapeutic doses which are greater and much more dangerous should be handled in the same manner as x-ray therapy. For I-131 alone and up to a year ago, 10 cases of acute leukemia had been reported after administration of I-131 for hyperthyroidism.⁵⁶ Possibility of such a causal relationship could never be denied. Management of radioisotopes in autopsies has been previously mentioned.⁴⁵ Personnel working in isotopes laboratories are constantly exposed to radiation hazards. They are subject to more risks than patients. Therefore, a radiation safety program is considered to be mandatory by the Atomic Energy Commission which certifies use of radioisotopes.

Radioisotopes will continue to gain increasing importance in the field of clinical medicine. More radioisotopes will be discovered and manufactured with greater ease. I-125 is already on the way to replace I-131. I-125 is more efficient than I-131 in therapy and diagnostic procedures. It will be cheaper to produce. Co-57 or Co-58, instead of Co-60, has been used in the Schilling test. The Co-57 and Co-58 have advantage over the Co-60 in the fact that they have a much shorter physical half-life. As time goes by, more diagnostic and therapeutic procedures will be-

come available. It is possible that in the near future coronary circulation of the heart can be easily evaluated through the use of radioisotopes. The equipment used to measure radioactivity will become more efficient and sensitive. Thus, there will be a lower tracer dosage which complies with the principle that the least radioisotope used, the greater protection there is against radiation hazard.

Summary

Present status of radioisotopes in clinical medicine is reviewed. Both diagnostic and therapeutic uses of the radioisotopes are individually discussed. Diagnostic uses of the radioisotopes are reasonably safe, while therapeutic uses of the radioisotopes carry a calculated risk because of radiation hazards. The need for a radiation safety program is essential. Radioisotopes will continue to gain increasing importance in clinical medicine, and understanding of application of radioisotopes to specific diseases affords the physician another tool in his medical armamentarium.

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Uneven distribution of coronary blood supply produces electric instability and fibrillation. Surgical treatment will improve myocardial circulation.

Coronary Heart Disease: *Analysis of Physiology and Treatment*

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CORONARY HEART DISEASE has a lost and found history—lost in the abdomen as acute indigestion and found in the heart some 42 years ago. In terms of history this was like yesterday. It was then discovered that the heart was an electrical organ and that electrical impulses could be taken from the heart and recorded on paper, as the electrocardiogram.

We are now at the brink of another discovery, namely that the heart produces a fibrillating current which can electrocute itself and that this current is produced by an uneven distribution of coronary blood. This current is dissociated from injury to heart muscle because it develops without injury. This death-factor is mobile. It can be prevented, in which case life is saved. It can be delayed, in which case life is prolonged. It can be reversed, in which case the fatal heart attack is not the end of life. These statements are discussed.

Discussion of Death-Factors

The disease begins with narrowing of a coronary artery. When the lumen of one artery is severely reduced or when it becomes occluded, an infarct in muscle is usually produced. These

structural changes in arteries and muscle can be observed in the dead heart, but structural changes do not give the complete picture of the disease.

Two additional components are needed: pain and electrical disturbances, and these can appear in the disease early or late. When they light early structural disease is slight. When they appear late, structural disease is severe and approaching the end point. If electrical death stays out of the picture then structural disease can run its course until coronary inflow is reduced to terminal levels when there is not enough blood entering the heart to support the heartbeat. When this occurs the death-factor is by inflow reduction. Or the muscle becomes so severely damaged that the heart fails and when this occurs death is by muscle destruction. Structural disease in arteries and muscle cannot be reversed. The arteries cannot be cleaned out and the scars cannot be turned back to muscle.

The other two manifestations of the disease which are physiological and not structural can be treated. Pain can be treated and so can the electrical disturbances before they go on to kill. Treatment consists in producing a more even distribution of blood in the heart muscle, done by moving blood from one area of the heart muscle where blood supply is good to other areas where it is not so good. Vasodilating drugs and the Beck operation accomplish this.

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Distribution of Coronary Blood

Distribution of blood in the substance of the heart manifests itself in various ways. It plays an important part in the physiological manifestations of all types of heart disease. The following points can be made concerning the general subject of oxygenation in the heart—(1) a well-oxygenated heart, pink all over, is free of pain and is electrically stable; (2) a poorly oxygenated heart, blue all over, is free of pain and is stable; (3) a pink, well-oxygenated heart with one branch of a coronary artery occluded is painful and electrically unstable; (4) a blue heart with pink, arterial blood perfused into one branch of a coronary artery is the same as (3). Well-oxygenated blood perfused into a coronary artery cannot produce injury. The old concepts of injury and injury current are not applicable here. Pain and electrical disturbances are produced by differences in oxygen content in heart muscle. Oxygen-differentials and checkerboard distribution are terms applied here. Pain and fibrillating currents are dissociated from injury. They occur without injury.

The anoxic heart, blue all over, stops in standstill and is not painful. Death by anoxia occurs in the following conditions—paralysis of the respiratory center, pulmonary disease, asphyxia, drowning and various forms of cyanotic heart disease. The checkerboard heart fibrillates and is painful. This type of death occurs in the presence of coronary heart disease, spasm of a coronary artery, embolus in a coronary artery and aberrant coronary artery. Conditions are illustrated in Figures 1 and 2.*

To Produce a More Even Distribution

It is obvious that treatment of coronary heart disease is related to distribution of the coronary blood supply. An even distribution of this blood cures the pain and removes the electrical disturbances that fibrillate. Emphasis should be placed upon distribution and the ways and means of making a uniform distribution. A large number of deaths occur when the total amount of blood entering the coronary arteries is adequate but distribution of this blood is not adequate. This makes the difference between pain and no pain,

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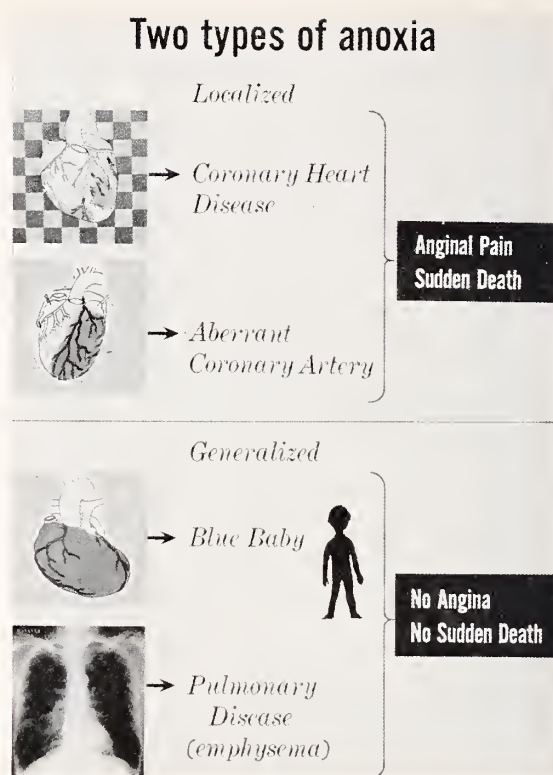


FIGURE 1

between a fibrillating heart and a coordinated heartbeat.

The amount of blood moved by the vasodilating drugs was measured in our laboratory.¹ Instead of finding these drugs to be ineffective as claimed by the physiologists² we found them to be effective. The amount of blood moved by nitroglycerin is 0.88 cc per minute and this transfer lasts for five to 10 minutes. Some of the other drugs are slightly more effective and last for a longer period of time.³ But none of these drugs produce permanent improvement in the circulation. Their action is temporary. It is significant that quantities in the range of one cubic centimeter per minute can give as much relief of pain as experienced by the patients taking these medicaments.

The Beck operation moves about five times as much blood as does nitroglycerin and the benefit of operation is permanent. (Figure 3) Our laboratory measurements on the operation are supported by the clinical results. On patients the superiority of operation over drugs is definite. Only the patient is in a position to make this comparison because he is the only one who experiences both types of treatment. The patient should be respectfully heeded in this connection.

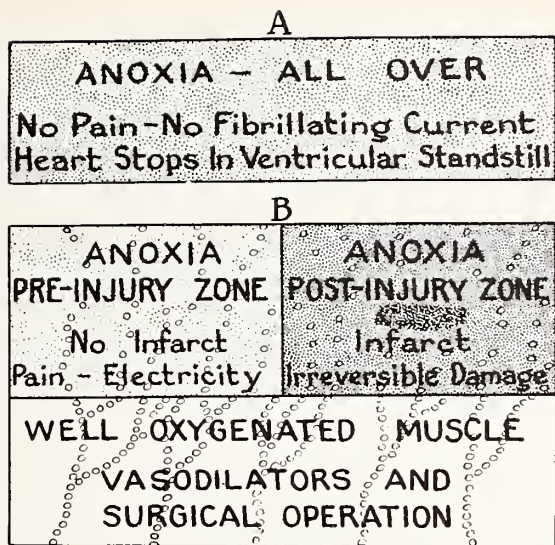


FIGURE 2

The Beck Operation[†]

This is a simple operation carried out on the surface of the heart. The purpose of the operation is to produce intercoronary communications so that the blood will be more evenly rationed. The operation consists of several steps one or more of which are omitted depending upon the irritability of the heart at the time of operation. The lining of the parietal pericardium and the surface of the heart are lightly abraded. A light application of 5% aqueous solution of trichloroacetic acid is made on the surface of the heart between major coronary arteries. Powdered asbestos is sprinkled lightly over the heart. The coronary sinus is narrowed to a diameter of 3 mm. The pericardium is left open. Fat outside the pericardium is spread over the surface of the heart to which it becomes adherent. A mild inflammatory reaction is produced and this in turn creates new blood vessels which connect one coronary artery with another. (Figure 4)

The initial effectiveness of the operation was measured under controlled conditions using laboratory dogs (Figure 5). The operation reduces electrical death by 44% when a test coronary artery is ligated. Test artery was the descending ramus of the left coronary artery. Type of death in these dogs was by electrical fibrillation. Mortality was determined in normal dogs and in dogs which had been protected by this operation several weeks or months prior to test artery ligation. Size of the infarct was measured in all dogs that

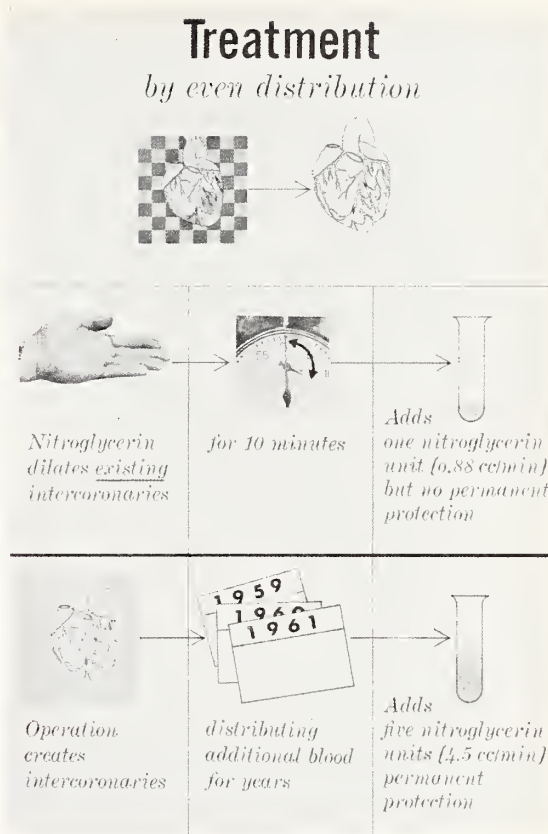


FIGURE 3

survived test artery ligation. Infarcts in the protected dogs were one-third the size of the infarcts in normal controls. Electrical disturbances were fewer after test artery ligation in the protected dogs than in the control dogs. Back flow determinations were increased 4.5 cc per minute by operation. This is five nitroglycerin units. The operation was well-tested. These tests indicate that this operation is the most effective method of treatment.

Selection of Patients

The operation is indicated in all patients with the disease regardless of the presence or absence of pain. In the absence of pain it is indicated to help prevent death by fibrillation. This, in itself, is adequate reason for it. Patients with terminal disease in arteries and muscle are not candidates for operation. For this reason operation is not recommended for patients in failure. The best patient is the young person with severe pain and no severe damage in the heart. All such patients should be operated upon because their hearts are too good to die. (Figure 6). After an

Beck Operation	
Creates _____	<i>Intercoronaries (by mild inflammatory reaction)</i>
Rations blood _____	<i>to best advantage</i>
Provides _____	<i>Greatest pain relief</i>
	<i>—Strength to work</i>
	<i>—Relief from arrhythmias</i>
	<i>—Better contractility (Ballistocardiogram)</i>
	<i>—Improvement to peripheral circulation (warm feet)</i>
Protects _____	<i>Against sudden death</i>
	<i>Increases longevity</i>
	<i>—Against muscle destruction</i>
	<i>Subsequent infarcts fewer and smaller</i>

FIGURE 4

infarct the operation is delayed for a period of six months for healing to take place.

Results of Operation

The sensation of tightness over the heart disappears immediately after operation. Pain over the heart and discomfort in the arm disappear early. Usually the patient states that he does not know he has a heart. The feet get warmer. Sometimes the patient is more alert mentally as though spasm of cerebral arteries is relaxed. They are ambulated in 48 hours; they walk the corridors of the hospital usually without pain except for the incision; they try themselves out on the stairs and they are discharged in 12 days. There are few exceptions to this early improvement.

The late clinical results are shown in Tables I and II. These results are impressive. It is significant that the results after four to six years hold up so well because the disease, by nature, is progressive and not static. It seems that intercoronary channels once they are produced may become larger in the course of time. Certainly they do not close off or disappear.

Mortality (Tables III and IV)

The mortality figures speak for themselves. Classification of salvage and non-salvage is made when the heart is examined at the time of operation. We can make a pretty good guess about classification before operation. The term salvage is used when there isn't very much left in coronary arteries and muscle. When the heart is badly damaged we believe the patient does not

have long to go. The operation does not restore arteries or muscle. Clinical results in some of these salvage cases are often better than we expect. The mortality two years and four years after operation is about one-half the two and four year mortality in non-operated cases. These are not controls in the strict sense of the term but they give an idea of the behavior of the disease in a large number of patients. In our research laboratory we have controls and we know the operation saves life after a coronary artery is occluded. It is significant that the protection in dogs is the same as it is in humans.

Reversal of Death

So far this discussion concerns anginal pain, prevention of ventricular fibrillation or retardation of its appearance. These three aspects of the disease are related to the way arterial blood is distributed to the heart muscle. The more even the distribution the less the pain and the less likely is fibrillation. The fourth aspect of the disease concerns ventricular fibrillation after it actually occurs. There is no doubt that discussion of reversal of death belongs here.

Technic of Reversal: The fibrillating ventricles do not pump out any blood and the brain undergoes degenerative changes in three to five minutes. Hypothermia to 30° C stretches out this period by about two additional minutes and should be applied as soon as possible.⁵ The emergency act at the moment of death is to restore the oxygen-system. This involves getting air or oxygen into the lungs and pumping the heart by hand to circulate the oxygen to the brain. To pump the heart by hand requires that the chest be opened so that the hand or hands can be applied to the heart although a recent report indicates that strong pressure over the precordium will empty the heart.⁶ If the heart can be pumped without opening the chest this will simplify the technic. The next step is to get the heart out of fibrillation. This can be done anytime after the oxygen-system has been restored. It is not an emergency. A large electrode is placed on each side of the heart and a current of about 1.5 amperes is passed through the heart. This current makes all the muscle fibers of the heart contract at one time. When the current is broken the fibrillation may disappear. If not, the shock is repeated. Massage of the heart is continued and small doses of adrenalin are given. In many instances the regular beat

will be restored. Training courses in this technique are available.

Reversal as Related to Structural Disease in the Heart

Whether or not the heartbeat can be restored depends upon the amount of disease in the heart. We have had instances in which contraction of the right ventricle was restored but the left ventricle did not contract because it did not get enough blood through the diseased left coronary artery. We have also had instances in which the muscle was severely damaged and the beat could not be restored. It is almost impossible to draw the line between those in whom the beat can be restored and those in whom it cannot be restored. We have nine successful reversals after fatal heart attacks in the University Hospitals of Cleveland. These people are living six months to five years later. They had recent damage in the heart—it being recent occlusion that brought them to the hospital. A former resident had success in a man of 76 years who had an aneurysm of the heart. This damaged heart was defibrillated. Total number of successful defibrillation from various hospitals is not known. We estimate the number to be around 50, and will increase as more attempts are made.

One successful defibrillation was started outside the hospital and completed in the hospital. This child received an electric shock from a carpet sweeper. She was transported three city blocks to a doctor's office. There the oxygen-system was restored after an interval of six to eight minutes. The body was carried across the street to a hospital operating room where the

heart was defibrillated and the chest was closed. Hypothermia was used. The child made a complete recovery.⁷

Another case might be mentioned. Cardiac standstill occurred in a child; the foster father, a physician, opened the chest and pumped the heart in his home; a member of the rescue squad took over the pumping of the heart while tracheotomy was done; the victim was transported to a hospital. Mechanical respiration was necessary in the hospital. The child died two days later. The respiratory center was paralyzed by an intramedullary glioma. This heart stopped in standstill from generalized anoxia.⁸

Adelson and Hoffman made a study of the hearts from 500 victims of fatal heart attacks from the Cuyahoga County coroner's office.⁹ Death occurred within an hour or two of the attack. Death occurred outside a hospital in the

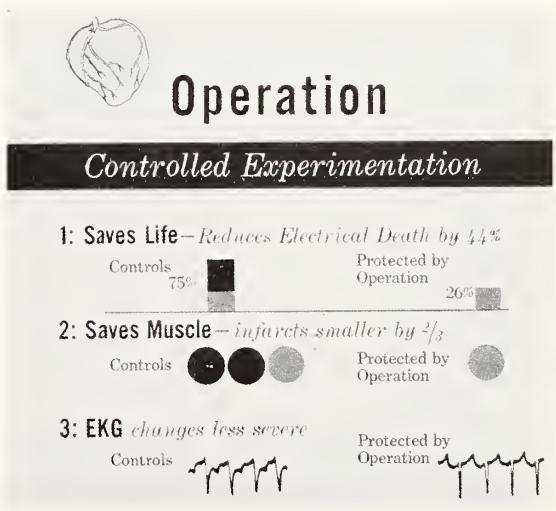
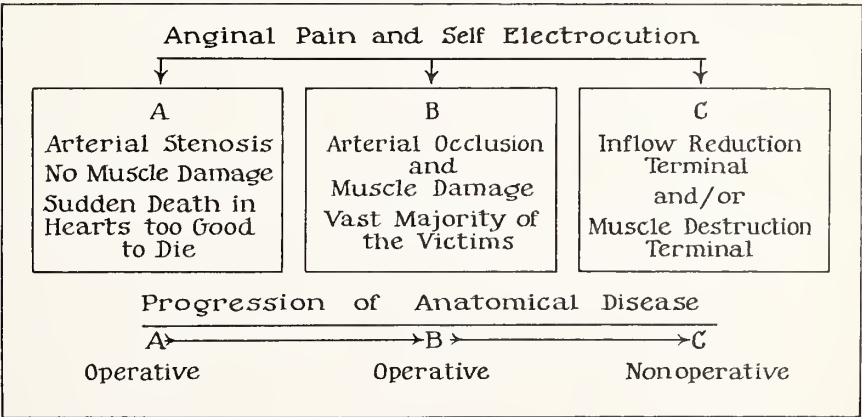


FIGURE 5

Spectrum of the Disease

FIGURE 6
ANGINAL PAIN and electrical fibrillation can light anywhere in the course of structural disease. Operation should be done early to protect hearts too good to die.



CLINICAL RESULTS
SIX MONTH TO SIX YEAR FOLLOW-UP
388 Patients

EXCELLENT— no pain—no medication	41.0%
GOOD— less pain—occasional medication	42.3%
TOTAL	88.3%

TABLE I

pursuit of ordinary life. In 316 of these, 63%, there was no recent disease in coronary arteries or muscle. In other words, if the victim died Aug. 10 the heart was the same on Aug. 9 except in the course of 24 hours an electric charge developed which fibrillated the heart. These authors stated that these might be referred to as "acute coronaries" but the only thing acute about them was the death itself. The death factor came and killed and disappeared and could not be found in the dead heart. Under proper conditions these hearts could be made to beat again.

The clinician has had experiences of death occurring in good hearts when the specimen did not show enough structural damage to account for the death. So-called mild occlusion often kills. Death often occurs after a patient is given a clean bill of health.¹⁰ The clinician states that he does not know the cause of death in these good hearts and needs the explanation which is contained in this paper (Figure 6) to explain the death.

This is an important subject because the number of people with good hearts who die is not small. It is important also because death can be reversed. A program of action is in order to reverse as many as possible. Special training is necessary for this program.

MORTALITY
492 PATIENTS OPERATED JAN. 1954
TO JAN. 1960

		(Non-Salvage 291)
Hospital	6.3%	3.4%
Subsequent, up to six years	14.8%	9.6%

TABLE III

CLINICAL RESULTS
FOUR TO SIX YEAR FOLLOW-UP
147 Patients

EXCELLENT— no pain—no medication	40%
GOOD— less pain—occasional medication	48%
TOTAL	88%

Classification improved in 10% during past year. Progression of disease lowered classification in 14% during past year.

TABLE II

Conclusions

This analysis of coronary heart disease differs from the deeply-rooted concepts of the past. In our opinion morbid anatomy is a strait-jacket for which little can be done. Anticoagulants are an exception to this statement. There has been discussion concerning the removal of cholesterol from the blood stream and also from the coronary arteries. So far, the disease is in about the same position as it was in the past and our problem is to deal with it as it now exists. Over and above morbid anatomy there are two physiological components which can light singly or together anywhere along the course of the disease. These are anginal pain and electricity which can fibrillate. These are produced by uneven distribution of coronary blood supply and they are treated by restoring an even distribution insofar as this is possible. The most effective treatment is that which produces the most even distribution.

The Beck operation is five times as effective as the vasodilating drugs and it provides permanent help. This operation saves life when an artery is occluded in the experimental laboratory by a ligature. In patients the four-year mortality

MORTALITY
206 PATIENTS OPERATED 1954,
1955 AND 1956

		7,400 Patients
Hospital	6.3%	(no operation)
Two Years	12.1%	25%
Four Years	20.3%	42%

TABLE IV

after operation is less than the four-year mortality without operation but these two groups of patients are not exactly the same. Operation should be standard treatment for this disease. It can prevent or delay death in your patient when the disease is not too severe. This death factor has been reversed even after it appeared. The number of victims killed in this way is not small; indeed, this is our modern scourge and we should take steps to do something about it both before it kills and even after it kills. A training course is available in our research laboratory and physicians are invited to enroll. There is no doubt but that we have new responsibilities and society is going to ask questions.

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ADDENDUM

Since this article was written considerable progress has been made in the method of reversing the fatal heart attack. It is no longer necessary to open the chest and pump the heart by hand to reverse death. The closed chest method has proven its value. Blood can be circulated by compressing the sternum over the heart 60 times a minute and by blowing air into the chest by mouth-to-mouth breathing. In this way the period of safety for the brain can be stretched out from the 3 to 5 minute limit to longer periods of time. Indeed this safe time interval is long enough to transport the victim from his death bed at home to the hospital where the heart can be shocked out of fibrillation and a normal heartbeat restored. Training courses are in existence to learn how to do it. In the last few months we have made a closed chest heart-lung machine which can keep the brain viable for periods of one hour or more and then the heartbeat has been successfully restored.

A revolution has taken place concerning one of the death factors of coronary artery disease. First, electrical death in a good heart can be prevented by the Beck operation done some time before the victim would have died. If the operation should not completely prevent electrical death it can delay death and thereby prolong life. Electrical death can be induced in a good heart by such activity as shoveling snow. This death factor is mobile. Now death can be reversed in a good heart after it occurs by timely intervention. Again this death factor is mobile; it can be moved around. This concept of mobility is as revolutionary as the discovery of the circulation of the blood by William Harvey 300 years ago and, no doubt, it is equally important. We have new responsibilities towards the victim of coronary artery disease. Indeed, the widow of the dead victim now turns to the physician and says "Do something, doctor." And there is something to do.

Some Complexities and Perplexities of

THE INVITATION extended by the *Journal of the Indiana State Medical Association* to pharmaceutical company presidents to contribute articles about the industry for publication is most gratifying. It is evident that the editor and his associates believe that responsibility for satisfactory health care must be shared. It is also indicative of the belief that better understanding of the problems of each segment of the medical care team will aid combined efforts to make health care in this country surpass even today's high level in quality and availability. Members of the pharmaceutical industry certainly concur in both beliefs.

Before industry activities are described in detail in future articles, I should like to make some general observations which, I hope, will help to put some of the complexities and perplexities of industry operations in proper perspective. In a sense, I shall be trying to describe some of the hazards along the obstacle course which all of us must run in providing good medical care to all who need it.



So Now . . .
Everybody's
An Expert!

A decade or two ago the average patient received his physician's prescription without question, accepting the fact that the meaning of those Latin hieroglyphics was none of his business. Today the doctor encounters all too many self-educated therapists who have their own ideas regarding the medication they should take. Disease and its treatment command public interest on all sides of us.

In this same period people also have moved in their thinking from an acceptance of certain limitations in man's ability to solve material problems to a feeling of confidence that nothing is impossible. Science, it seems, has given us a magic lamp which needs but a little rubbing to

Pharmaceutical Industry Relationships

*EUGENE N. BEESLEY, President
Eli Lilly and Company
Chairman, Board of Directors
Pharmaceutical Manufacturers Association*

make miracles. And along with this, the public has been led to believe by proponents of government spending and government control that every miracle can be made to happen overnight.

There can be no quarrel with the rightness of the desire to wipe misery, poverty, and disease from the face of the earth; but if supercharged criticism of practices and policies which have made for progress in medical care leads to unwise government intervention and controls, the interests of the public will not be served. To prevent such from happening is one of our basic problems at this time.



**"Strangers"
Are Fair Game
For Criticism**

It is human nature to believe gossip and criticism about a stranger more readily than about someone whose integrity and good works are

well known. Until recent times the medical profession had little reason to be concerned with the operating problems of the pharmaceutical industry; and even today, as far as the general public is concerned, the industry is almost a complete stranger.

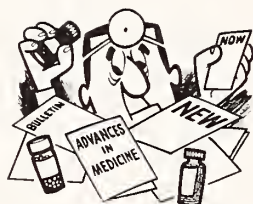
In our zeal to avoid any possible intrusion upon the relationship of the physician with his patient, ethical pharmaceutical manufacturers have over the years shied away from communication with the general public. Thus, inadvertently we have aggravated severely our present public relations problems.

It is now apparent that the press, public and government will allow no choice as to whether there is public communication about health matters. The possibility of keeping new developments in the field of cancer, heart disease or poliomyelitis off the front page is extremely slight. Thus, a problem which the pharmaceutical industry faces is continuing its traditional role of working with the practicing physician on a high ethical and scientific plane and, at the

same time, finding ways to communicate effectively with the public without intruding upon the physician-patient relationship.

In this age, when rapid communication is "too much with us," it is, indeed, perplexing to know how to meet the demand for public information about health and medicine without creating a nation of hypochondriacs and amateur physicians.

Research Successes Bring Progress and Problems



The profusion of therapeutic advances resulting from success in scientific research has brought to the practicing physician the problem of how to keep up to date with the many significant new medicines.

Medical school curricula and postgraduate medical education programs cannot provide all of the help which he needs. In my opinion, the time lag between laboratory discoveries and their practical application in the hands of the physician has been reduced by the pharmaceutical company salesman and the company's medical staff which stands behind him.

Without attempting to justify all pharmaceutical promotion, I believe that the industry's efforts along this line have benefited the medical profession and the general public. The industry must continually strive to make its promotional services more valuable to the physician. It also must find a way to get a better understanding of its promotional efforts to people in government and in the communication field particularly.



Economics of Distribution Obscure to the Public

The observation can properly be made that the general public does not adequately understand the economics of consumer product distribution in any field. This is especially true for pharmaceuticals and biologicals. The public does not appreciate the fact that, if adequate supplies of fresh stocks of medicines are to be available in every corner drug store and hospital across the land, the cost of fast and convenient distribution through professional channels must be met. I doubt very much that most people realize that about half of each dollar which they spend at the prescription counter goes for the handling of their medicine—not for the making of it.

When it comes to meeting criticism of "high" drug prices and "profiteering," the pharmaceutical manufacturer has self-imposed restraints upon his communications with the public. For the most part, the consumer has no way of knowing what the manufacturer charges because fees for the pharmacist's services become a part of the total price which he pays for his medicine. This is quite proper, but it means that the manufacturer needs the support of those in the medical care field who have direct contact with the patient to help explain the price and value of drug products. The physician, the pharmacist and the manufacturer all have an important stake in satisfying the patient that he is getting his money's worth when he purchases medical care.



Medical Care Is a Political Clover Patch

To come back to the subject of government and medicine, a sizable hazard on the obstacle course of medical care stems from the very nature of politics and the desire of every politician to promote what is good for the people—or thought to be good because of its popularity. As you in medicine know—probably better than anyone—this makes free medicine, free medical care, free hospital services most appealing causes for elected representatives to support.

This will, no doubt, always be true. Also, it will probably always make investigations of the drug industry popular political pastimes.

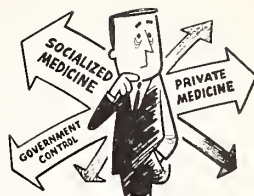
Ethical pharmaceutical manufacturers have been castigated in some quarters for their emphasis on the importance of quality control in their manufacturing processes and for standing behind brand names for their products.

Our critics have blithely said that the U. S. Pharmacopoeia and the Food and Drug Administration are all that the public needs to guarantee the potency, safety and purity of its medicines. Without in any way impugning the Food and Drug Administration and its conscientious handling of its responsibilities and without in any way discounting the value of the U. S. Pharmacopoeia, I do not hesitate to make this observation: Quality cannot be *inspected* into a product; it must be *built* into the product at every step of the manufacturing process.

This means, quite without exaggeration, that if federal inspection of drug products were ever to be the sole guarantee of their potency, safety and purity the FDA would need to have an inspector alongside every production operator and every control chemist in every drug manufacturing company in the country. Fortunately, the public is safeguarded by the reliability of the manufacturer and his willingness to stake his reputation upon the quality of his products.

It would be unforgivable, in my opinion, to delude people into thinking that Big Government alone can protect the quality of their medicines any more than Big Government can give them "free" medical care.

Where Do We Go From Here?



We in the pharmaceutical industry are under no delusions that perfection has been achieved in our field. Improvements can be made—and I am confident they will be made.

While striving for better ways to research, produce, and distribute drugs, we cannot, in good conscience, stand by and witness the undermining of basic principles and practices which have helped to advance medical care in this country. Responsible people in government, the professions, and in all walks of life must be alerted to the dangers which confront our medical care system. They must be provided with information which will enable them to evaluate proposed remedies for its alleged shortcomings. They must satisfy themselves that something better is really available before relinquishing something which works much better than its critics will admit.

I doubt that taking medicine will ever become popular or that the industry which makes medicine will ever win a popularity contest. I am optimistic enough, however, to believe that the pharmaceutical industry can make itself known for what it is and can fully earn the public's confidence and respect. I am hopeful that, for the most part, the industry has the confidence and respect of the medical profession and that it can continue to demonstrate that it merits both. ◀



The Case of Misfortune's Stepchild

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WITHOUT BEING superstitious, we all have observed that some people are just naturally lucky: nothing unpleasant ever happens to them. Others seem to have been born under an evil star; misfortune dogs their every step; the ever-angry Furies of mythology, are their constant companions.

Obviously, it was not Giacomo's fault to have been conceived at just the wrong time—for the Novello family, that is. Papa Novello already had two children when he received the good news that his brother in New York had saved the cash to pay for passage which would take the Sicilian family across the Atlantic to America. This promised miraculous release from the crushing drudgery that was the common inheritance of the ever-hungry, malaria-chilled, Mafia dominated, naked and illiterate, vermin-infested Sicilian peasant.

At this happy juncture, Mama Novello, being seven months pregnant, traveled with the family

only as far as Palermo. In that city, eclampsia felled her; edema and nausea she bore stoically but the vomiting weakened her so that she simply could not stand up; a city ambulance took her to the maternity ward of the hospital. Papa Novello and the other two children simply *had* to sail, steerage, without her—there just was no money for anything else. Miraculously enough, Mrs. Novello survived a stay of more than a month at the lazaretto, the only public medical facility that had a spare bed in those turbulent days of the summer of 1914.

A Serbian student had just assassinated the Archduke of the Austro-Hungarian empire; Europe was girding for war; mobilization was taking the best medical brains and supplies; the abandoned peasant woman in labor did not receive what we would call even a reasonable facsimile of decent care. Still, the nuns were kind and she was tough; the puling infant's head was sprinkled with holy water before the um-

bilical cord had been cut as it was not thought that the baby would remain long among the living. In the haste of a rapid delivery by an unskilled accoucheur, Giacomo's face had been damaged badly: the right eye had been squished so that the external rotator was torn from its attachment, the right angle of his mouth had been ripped and re sewn, with but a single crude stitch. The net result to his face was a permanent, grotesquely malevolent, squinting scowl that gave the baby an "evil eye" appearance.

Both mother and infant clung tenaciously to life. Papa Novello had caught the last immigrant boat to sail until the war ended four years later. Giacomo and his mother could not get passage until 1919. In his first few years of life, Giacomo acquired the exaggerated stigmata of severe rickets; he developed tuberculous osteomyelitis of the spine with an ilio-psoas abscess, collapsed lumbar vertebra and a repulsive kyphoscoliosis; he also had an assortment of intestinal worms, estivo-autumnal malaria and a bout with typhoid fever.

All in all, Giacomo Novello started life more than a little handicapped by a monstrous concatenation of strokes of misfortune.

While disembarking at Ellis Island, Giacomo slipped on the gangplank. Normal children would have skinned a knee—Giacomo sustained a greenstick fracture of the right femur. He was hospitalized and the leg was put in traction; he was dewormed, deloused and somewhat rehabilitated physically. A prolonged stay at Bellevue corrected, slightly, the terrible humpback deformity. He gained weight, got rid of the malaria, had plastic surgery on the torn eye muscles and that unfortunate cheek. In the process, Giacomo learned also to speak, read and even write some English.

Still, the results at discharge were less than average. The fracture of the femur had healed maybe passably but the boy was left with a very noticeable limp. Also, the plastic procedures on his face had suffered from various mishaps so that the results could be classified only as fair to poor. If the reader will recall Quasimodo, in Victor Hugo's immortal classic, *The Hunchback of Notre Dame*, then we could describe Giacomo as having been changed from a miniature Lon Chaney in that role to a passable imitation thereof.

Fine Mind . . . Deformed Body

Curiously enough, a fine, sensitive mind dwelt writhingly within the grotesque flesh. This was to become part of the tragedy of Giacomo's life; it set the pattern for his role of *Misfortune's Stepchild*; his parents and siblings were dull and phlegmatic, but their bodies were solidly healthy. He was brilliantly intelligent; from earliest childhood he was to know just how galling were the bonds that bound his soaring spirit to the narrow, physical confines of his dwarfed, deformed body.

Prolonged hospitalization had exposed Giacomo's mind to the realm of books. Ever afterwards, he was a voracious reader, an insatiable observer of the passing scene, a keen judge of the beautiful life that was so definitely being denied to him personally. The Novello menage put in a few years in New York, then drifted to Pittsburgh; still later, Father Novello got a job



doing unskilled labor in the open hearths of the U.S. Steel Company that smokes up the skies of the southern suburbs of Chicago.

That is where I came to know Giacomo. One summer's day, shortly after I had opened my office, the pediatrician next door called me, "Oh! Arnold! I'm overdue at the hospital and I just had an emergency call: the hunch-backed son of the family had a door slam on his hand. He is an unlucky boy: assume complications and expect the worse with *that* lad. And, oh, yes! collect a reasonable fee; they are struggling along but they pay—always." He gave me the address of the Novello family.

The door had caught the tips of the middle three fingers of the right hand; the nails had bounced off and the flesh was stripped off the sensitive finger pads so that the bones were visible. A crude tourniquet had been applied above his wrist; the hand was immersed in a pan with ice cubes, the water being bright red from continued, rather brisk ooze of blood. His expression was something that I shall remember always. The youngster had tears in his eyes but he was biting his lips in a manful effort to stifle all outcry. The keen intelligence was fighting fiercely to master the clumsy body that had failed him yet another time. There was courage, rebellion, self-loathing and abnegation; a tempest of emotions that was incongruous and yet, somehow, vastly appealing. I forgot the physical deformities as I proceeded about the business of giving first aid to this plucky teen-ager.

Nemesis Still in Pursuit

It did not take long for us to become quite friendly. The boy had to come to the office for dressings and such things. He never whimpered at all the complications that did develop. Of course, I was far from being the best surgeon available but the pediatrician had never been more prophetic than when he had warned me. Many months elapsed before the fingers were healed. The lad was always cheerful and each time would take a fresh book from my shelves in exchange for the book that he had borrowed the time before. His choice was amazing in its ranging selectivity; he went through my little library like a weevil through a cotton boll. The questions he asked taxed my knowledge to the limit! He digested it all and clamored for more. I was barely twice his age and we became fast friends by the time the hand—finally—healed.

A year or so later, Giacomo limped into my office not to read or play chess, but as a patient with a new symptom; if he walked a mere block, the right knee would become painful. The joint did not feel hot or swollen; there did not seem to be any limitation of motion; no glands in the groin could be made out. An x-ray seemed to be entirely within normal limits showing only residues of the long-healed fracture; blood and urine examinations were completely routine. It certainly did not resemble rheumatic fever, rheumatoid arthritis or any other serious malady. I did, however, have an uneasy memory of the long-quiescent tuberculosis. Remembering Giacomo's penchant for trouble, I asked the pediatrician to look at him. The experienced clinician also found nothing; still, pain continued and the newly-opened Chicago Clinics were suggested for a consultation.

Dr. Phemister, Chief of Surgery at the clinics, told me, "I agree that this knee should be looked at rather soon; I do not like the *feel* of it." So, the very next week, at his invitation, I scrubbed at the operation. The nurse applied the tourniquet, the usual preparations were done and the surgeon swiftly opened the knee joint. I was relieved not to see the destructive, caseous lesions I had dreaded. Just as I thought that he would flush the operative field with saline prior to closure, the quadriceps tendon was drawn to one side. Underneath it could be seen the merest smidgin of some rather friable tissue. The surgeon half nodded his head as though the finding was the thing he had expected: methodically, he snipped off the aberrant flesh and dropped it into formalin. Quietly, he placed a towel over the exposed tissues and sat down on a stool with the low-voiced remark, "Let us wait for the frozen section."

Soon enough we both could peer through the microscope. Giacomo's nemesis was still in relentless pursuit: the whorls of cells were *SARCOMA*, low grade but unmistakable . . . The surgeon nodded his head taciturnly as if he had been expecting this denouement right along, "Of course, we agree that I have to disarticulate at the hip!" I was too stunned to argue the obvious.

As Giacomo lay convalescing, I found time to see him often. It was a revelation to see him grapple with the disaster that had overwhelmed him. He even developed a game on the topic.

One day, he told me gravely, "I am Timur-i-Lengh, the lame Tartar conqueror!" We played at his giving orders in that role: Timur-i-Lengh, Tamerlane, the terrible descendant of Jenghiz-Khan, the scourge of the world. What gave Giacomo the willpower to outface this terrible catastrophe? It was mind triumphing over matter; the ugly body emerged almost beautiful as one watched the spirit grapple with the dross of the mundane physique—and emerge victorious!

Ambitions Crowned with Success

About the time he had been fitted with a prosthesis and had begun to learn to get around by himself, Giacomo came to the office; his parents were with him. "Dr. Lieberman, please, fill out these papers for me; I need some recommendations for entrance to college. After I graduate from high school, I want to become a biology teacher . . ."

Dumfounded, I gazed at the lad. "Do you realize what you are getting yourself into? After the four years of college, do you think that you will be able to get a teaching job so easily? Will you be able to take the cruelties of the faculty and the students in stride?"

"But, doctor! I *must* study or just go mad while waiting for a possible recurrence! *If* it comes back, I'll never finish; *if* I finish: that will mean that I will have been cured!"

There was a tinge of awe in my admiration for the determined cripple. I filled out the papers. Over the ensuing years I helped him all I could with his studies, although Giacomo never encountered any scholastic difficulties. I was lucky enough to wangle a few scholarship dollars for him by crying on the right shoulders, and that was a big help. Incredibly enough, success crowned his perseverance. He graduated from college; then went on to get a master's degree. A chairman in the department became interested in the plucky young man and obtained for him a modest but eminently fine job as a research assistant on the campus of a nearby college. Giacomo did very well indeed. Everyone admired his quiet modesty, immense learning, fantastic courage in the face of adversity and intense dedication to his profession. Giacomo Novello became a thoroughly-respected member of his community; he joined such organizations as the Knights of Columbus, Community Chest, etc. . . . I was startled to meet him one day and learn that he was in love—and that the feeling

was reciprocated! I was proud to be invited to the wedding; no one thought it odd for so beautiful a young woman to marry a man so gravely handicapped physically.

Well, time went by and the young folk even begot a child; his cup was full; fate seemed to have relented. By sheer tenacity of will and brilliance of mind, Giacomo appeared to have out-faced the Erinyes—the Furies—which had so dogged his earlier years. The young couple settled into quiet domesticity; Giacomo became active in P.T.A., his church, civic affairs and campus promotions came in expected sequence—all seemed well.

. . . Ornery as all Get Out

World War II came along and I lost contact with Giacomo; of course, there was no question of his joining the Army. I did hear of him at times and was genuinely happy about his growing reputation as a scholar, teacher and family man. And then one day I bumped into an old friend who had seen the young Novellos recently. He repeated some gossip about Giacomo that disturbed me. "You know, our friend Giacomo has been acting queerly. We all know that he is working very hard and that he resents not being able to join the Army in any capacity whatever. But gosh, almighty! He is barely past 30; we all know his handicaps but that is no reason for humiliating that wonderful wife of his in public; or, for always being AGAINST whatever is being proposed. He is getting as ornery as all get out: I don't know what is eating the guy." Vague apprehensions were aroused in me; there was nothing I could do; I let the matter slide.

In 1953, I was in Montreal attending the International Physiological Congress; astonishingly enough, I ran into Giacomo Novello. I started to greet him eagerly; imagine my utter bewilderment when he seemed to fumble a bit before recognizing me! Of course, a decade had passed since our last encounter—but even so. He recovered himself fairly well; his conversation was rational enough; certainly, he was friendly as friendly could be. Still, the usual zest and sparkle of his brilliant intellect seemed strangely missing. Also, there was a jarring querulousness and pettishness that just was not in character. This was *not* the Giacomo Novello that I had known and admired.

Later, his devoted wife came up to see me alone. She knew me well enough to talk without

restraint. There were tears in her eyes as she said, "Giacomo is changing so; I'm actually afraid for junior and myself. I feel as if he is withdrawing into a thick fog. The neurologist is talking of a possible premature cerebral degeneration but there is nothing definite, Dr. Lieberman, I'm *so* afraid. . . ."

My efforts to bolster her spirits were less than convincing: I did not know the answer but I just *knew*—intuitively but with absolute sickening certitude—that nothing good could happen to Misfortune's Stepchild. I did write to the doctor handling the case and received a reply with a possible differential diagnosis including such items as Pick's Disease and Alzheimer's in addition to various dystrophies, myelin sheath degenerations: a cloud of words concealing (but thinly) professional bafflement. To my shame, I let the matter drop there.

More years went by. The AMA was having a convention in New York and I was browsing through the scientific exhibits. The fresh pathology drew my attention; an earnest U. of Chicago resident was presenting a case that had come to surgery (and autopsy) that very week. The large brain tumor was found only at postmortem; the view-box held slides of the microscopic sections; the tumor itself lay on the tray. The pathologist was calling attention to the bizarre features of the case: it was a solitary growth of definite even if low-grade malignancy; there was no real capsule and there was a slight infiltrative tendency. The resident waxed eloquent as to the baffling nature of the cells causing the lesion, "obviously, they are not composed of any true nervous tissue so we must assume an endothelioma or, maybe, a mesothelioma of some sort. These cells are flattened and resemble a sarcoma of some sort."

Timur-i-Lengh's Destiny Fulfilled

"The patient was a mis-shapen dwarf with a marked tbc of the bones. Those lesions, however, were old and inactive. As we can all see, there is nothing granulomatous to be seen in any of the sections. We had also thought of a possible old traumatic cyst because he had given a history of losing a leg and having his face scarred by an accident in his youth . . ."

There was a sudden tinkle of bells in my mind; I could almost feel the hairs in the nape of my neck rise. "Did you say that it was his *right* leg and a poor plastic on his *right* cheek?"

"I didn't, but it sure was. . . ."

"And, tell me, doctor! Was there an internal squint on the same side?"

"Why, yes! I did not know you had seen the case; your badge tells me you are from New York—not Chicago."

My mind was on other things; I was not listening too closely. "I see that you give the patient's initials as T.L.; may I ask the full name?"

The pathologist looked puzzled but was willing to thumb through the record. "Oh, yes! Now I remember! It is a bit heathenish: Timur-i-Lengh it was; the original entry was Tim Lang but the patient was very fussy about having it just so."

Of course, it had to be Giacomo Novello! I was looking at the section in the view box but I could hear—still so plainly—the surgeon saying quietly, "We agree that I have to disarticulate at the hip." The tissue was the same; I was looking at a solitary metastasis from the original sarcoma of the knee!! It had waited 25 years and more before killing its victim, but kill Giacomo Novello it did. But why did fate have to first



dissolve the magnificent mind and personality that had been Giacomo? Why the grim tragedy of the apparent respite followed by the slow erosion of the physical base of that radiant being so beloved by all that knew him? Why had he crawled back to the University Clinics—under that pseudonym, of all things? How could I have been so negligent in not following through on our Montreal encounter? Not malice, of course . . . just careless neglect—preoccupation with other things more immediately at hand . . .

I was chastened almost to the point of nausea as I wandered away from that fateful exhibit. Why had the patient failed to mention the original operation? Why this history of an “accident” in his youth? I did write to the pathology department at the University re my departed friend. The usual courteous reply stated briefly that, “Mr. Giacomo Novello was last seen by us in 1936, there were no neurological changes found

at that time.” I looked at the signature of the chairman of the department for a long time. Should I contact the family? His former friends? Re-open old scars?

My hesitation was prolonged; now I’ve decided to state the facts of the case. I think that with the last flicker of his remaining intelligence, Giacomo had really wanted me to do so; what other reason could he have had for signing in as Timur-i-Lengh, our long-forgotten, private name? That is the reading I give to that cryptic pseudonym. Most tardily and inadequately, I am trying to pay my last respects to Misfortune’s Stepchild. Maybe, some of his old friends will scan these lines and have more sympathetic recollections of the brilliant mind and glowing personality that resided so unhappily in such a grotesque body. Requiescat in Pace. ◀

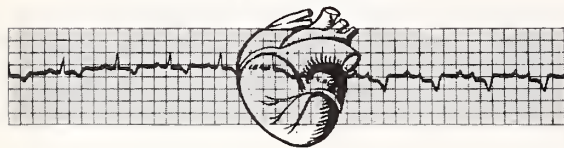
1270 Fifth Ave.,
New York, N. Y.

The Miasma of Jargon

I warn you of a new kind of jargon, whose cotton-wool coils are being wrapped closer around us every day—the jargon of officialdom and the jargon of committees. In this malignant hypertrophy of language, nobody says anything: they “state” or worse still, they “intimate that.” They never think: they “are of the opinion that.” Nobody finishes anything: it is “duly completed.” Nobody is paid: they “receive financial remuneration on a 9½/11ths basis.”

Nobody looks ahead: they “envisage a long-term policy.” This language is a waste of duplicating-paper and a waste of time. Incompetence can hide behind its opacity, and activity be smothered by its voluminous folds. I warn you of this deadly and contagious miasma. May I personally intimate to you that after due consideration I am of the opinion that it should be an integral part of your basic policy to take due precautionary measures against this obnoxious prolixity?—Richard Asher: Making Sense. *Lancet*, Sept. 19, 1960. Reprinted in *The Armed Forces Medical Journal*, December, 1960.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Unusual Form of Intraventricular Conduction Defect

*CHARLES FISCH, M.D.**

Indianapolis

THE PATIENT was admitted to the Marion County General Hospital, Dec. 20, 1960, because of mental confusion which had been present for some months. Past history revealed that he had enjoyed good health. Physical examination on admission revealed a well-developed, well-nourished man, age 76. His blood pressure was 110/80, pulse was 108 and regular.

Examination of the chest showed some increase in the AP diameter and diminution of expansion. The heart was enlarged to the left and the heart sounds were distant. Chest x-ray showed depression of the diaphragm and enlargement of the heart with a left ventricular configuration. EKG showed a normal sinus rhythm with a P-R measuring .32 seconds. The QRS was widened, measuring .12 seconds. In

the frontal plane (leads I, II, III, AVR, AVL, AVF) the configuration of the ventricular complexes is that of left bundle branch block with deep S waves in leads II, III and AVF. Inspection of the precordial leads (V-1—V-6) shows tall upright R and R' on the right side of the precordium (V-1—V-3) with deep S wave on the left side (V-6). The precordial leads thus indicate a right bundle branch block.

This is an unusual EKG pattern in that it resembles left bundle branch block in the frontal plane and right bundle branch block in the horizontal plane. Such a pattern has been variously described as "masquerading" bundle branch block, incomplete bilateral bundle branch block and left ventricular hypertrophy with terminal conduction delay. The exact mechanism of this abnormality is obscure. Some believe that the defect is due to partial interruption of both bundles; others believe that the superior and anterior orientation of the QRS complexes is due to a massive infarction of the diaphragmatic, lateral and posterior walls resulting in non-cancelled force directed superiorly and anteriorly.

* From the Robert M. Moore Heart Clinic, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and Indiana State Board of Health.

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12-30-60

1
2
3

AVR
AVL
AVF

V-1
V-2
V-3

V-4
V-5
V-6

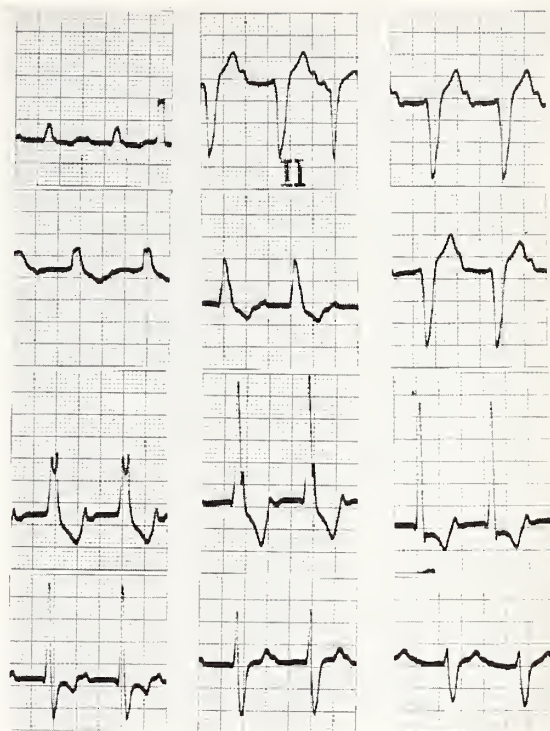


FIGURE 1

NORMAL SINUS RHYTHM with a P-R of .32 sec. Note the left bundle branch pattern in frontal leads (I, II, III, AVR, AVL, AVF) and the right bundle branch block pattern in the precordial leads. (V1-V6).

Left ventricular hypertrophy with terminal delay of depolarization and anteriorly directed vector can result in a similar pattern.

In each instance an attempt is made to derive

an anatomical lesion from electrical potential recorded on the body surface and admittedly such a deduction is more often than not impossible. ◀

CONFUCIUS SAY:

He who is big false front for "sink test lab" also go down drain in the end.

Translation from Chinese follows:

He who lends medical license as front for a laboratory now must pay federal income tax on total income of same!

We thank you!

INDIANA ASSOCIATION OF PATHOLOGISTS

LABORATORY MEDICINE

Published periodically as a review of clinical laboratory procedures suitable for laboratories with minimal equipment.

C-Reactive Protein

*A. WENDELL MUSSER, M.D.**

Indianapolis

FOR YEARS the sedimentation rate of erythrocytes has been a guide and measure of activity of many infections or inflammatory diseases. Recently the C-reactive protein test has begun to replace the older sedimentation rate.

In 1930 Tillet and Francis found that in certain infectious diseases, notably lobar pneumonia, the serum obtained from patients during the acute stage of the illness yielded a precipitate in the presence of dilute solutions of the C polysaccharide of pneumococcus. The C-reactive protein is an abnormal protein which appears in blood in the acute stages of various inflammatory disorders and which is undetectable in the bloods of healthy persons. This protein is an alpha-globulin, and its production is stimulated by bacterial infections, various pyogenic agents, such as typhoid vaccine or the products of injured tissue, as in myocardial infarction.

MacLeod and Avery first isolated and purified C-reactive protein in 1941. It was later discovered that an antiserum could be produced by injecting the purified protein into rabbits. This antiserum is used for the demonstration of C-

reactive protein in human serum by the employment of a simple precipitation test.

Rheumatic Fever Activity Guide

C-reactive protein is invariably present in the sera of patients with rheumatic activity as well as in sera of patients with low-grade rheumatic activity. This test is said to be extremely reliable as a guide to the activity of rheumatic fever in a patient. This test is not specific for rheumatic fever but the absence of C-reactive protein rules out rheumatic activity.

Advantages of the C-reactive protein test over the erythrocyte sedimentation rate are: the sedimentation rate may be elevated without inflammation, as in anemia, pregnancy, convalescent stage of infectious disease, nephrotic syndrome, and hyperglobulinemia; the sedimentation rate may be normal in cases with frank rheumatic activity in the presence of congestive heart failure. In such cases, C-reactive protein, which is present only in inflammatory conditions, is a valuable adjunct or substitute for the sedimentation test. This test is also of use in such entities as lupus erythematosus.

At the present time the C-reactive protein test is accepted as a valuable aid in the diagnosis of

* From the Clinical Laboratory, Indiana University Medical Center.

low-grade, questionable rheumatic fever, in following the course of this disease during treatment, and in the differential diagnosis of coronary insufficiency, particularly as to the presence or absence of myocardial infarction and cessation of inflammation.

Method

Collect fasting blood from a finger-stick in a small clean non-capillary dry tube. After serum has formed, draw up C-Reactive Protein Antiserum to $\frac{1}{3}$ of the length of a capillary tube. (Inside diameter 0.4 mm; length 90 mm.) Wipe tube clean. Draw up an equal amount of patient's serum into the same capillary tube. Slowly invert tube several times to insure proper mixture of serum and antiserum. Do not allow air bubbles to form. Place finger over the top and insert tube upright in clay surface rack. Make certain the bottom of the serum column is 5-10 mm above the clay surface. Place the rack in 37° C incubator for two hours. A preliminary reading may be made at the end of this time. The presence of precipitate indicates a positive reaction. Place the rack in refrigerator (4° C) overnight.

Report the results according to the character of the precipitate.

0 = no visible precipitate

trace = a very slight reaction

1+ = 1 mm. column of precipitate; definite but slight reaction

2+ = 2 mm. column of precipitate; moderately strong reaction

3+ = 3 mm. column of precipitate; strong reaction

4+ = 4 mm. column of precipitate; very severe inflammation

In cases in which the precipitate is dispersed throughout the fluid column, the reading may be obtained from the summation of the total dispersed precipitate.

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unsurpassed "general-purpose" steroid outstanding for "special-purpose" therapy

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UNSURPASSED "GENERAL-PURPOSE" STEROID
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ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in treating allergic respiratory disorders, including bronchial asthma. Clinical evidence has now shown that ARISTOCORT is also highly valuable for "special-problem" patients—asthmatic and others—who, because of certain complications, were hitherto considered poor candidates for corticosteroids.

for example:

PATIENTS WITH IMPENDING CARDIAC DECOMPENSATION

In contrast to most of its congeners, ARISTOCORT is not contraindicated when edema is present or when cardiac decompensation impends.¹

PATIENTS WITH EMOTIONAL AND NERVOUS DISORDERS

Triamcinolone did not produce psychic disturbances or insomnia.²

PATIENTS WHOSE APPETITES SHOULD NOT BE STIMULATED

Among patients treated with ARISTOCORT, there was less appetite stimulation, especially in those who had previously gained weight on long-term therapy with other steroids.³

PATIENTS WITH HYPERTENSION

There was no blood pressure increase in any patient treated for bronchial asthma, and in some, blood pressure fell. Of these, three had been hypertensive.⁴

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).

Also available—syrup, parenteral and various topical forms.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.



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Continuing Investigation of Chloramphenicol

THE FOOD AND DRUG Administration, by request of the National Research Council, has conducted a continuing investigation of Chloromycetin (chloramphenicol) since the 1952 scientific inquiry when the drug and its propensity for occasionally causing blood disorders were studied.

In 1952 it was recommended that the drug remain on the market but with label warnings against its use in minor infections, and with advice for adequate blood studies with prolonged or intermittent use.

Reports since 1952 of severe blood disorders have prompted further study by a committee of distinguished physicians appointed by the Research Council. New recommendations are that the drug remain on the market for use in hospitals and for treatment of patients in the home, but with new and more specific label warnings and with inserts in each package detailing the warning and outlining precautions.

The insert will probably read as follows:

"WARNING: Serious and even fatal blood

dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after administration of chloramphenicol. Blood dyscrasias have occurred after short-term and with prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective or in treatment of trivial infections such as colds, influenza, viral infections of the throat or as a prophylactic agent.

"PRECAUTIONS: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia."

Polio Immunization

*P*OLIO still remains a serious public health menace. Estimates are that 40% of the population has not been immunized with Salk vaccine, —38% of children five years old and under, 63% of men between 20 and 40 and 48% of women between 20 and 40. A large part of the unvaccinated group is from low income areas.

No one knows when oral polio vaccine will be available. It is certain that it will not be ready for the 1961 polio "season." To control epidemics it is essential that much more than 60% of the population be vaccinated.

The Surgeon General's Committee urges that in 1961 every person be fully immunized against polio.

Immunization campaigns should be intensive in neighborhoods with less than 85% vaccination in groups under age six, where epidemics are most likely to occur.

The first priority groups to receive complete and early coverage should be infant and preschool groups under 6 years of age. Other children under 10 and parents of young children comprise the second priority group.

She'll Be Coming Down the Mountain

*A*T THIS REMOVE, after 12 years' experience with its health service Britain is plagued by its ever increasing and snowballing cost which is now double what it was initially. The financial misery is compounded by the 11% increase this fiscal year; these increases having occurred in the past few years in quasi-arithmetical progression, and the frightening thought that it may get out of hand is far from engaging, to be sure.

Attempts to keep down the costs have been made by charging for prescriptions, dentures and spectacles. At the moment there is an uproar in Parliament over the proposals to impose a charge directly upon the beneficiaries. In short, Paradise Found is fast becoming Paradise Lost, thanks to the malingerers and hypochondriacs using every discipline of medicine.

There is in the offing a cisatlantis analogy. We are told that costs for government medicine for the aged—the first step towards the welfare state

—will not be an addition to the budget because there will be an increase in Social Security taxes as paid by employers and employees, you and I. However as one whose illusions were sullied long ago, I feel bound to point out with flippant irreverence that the indeterminate nature of future tax increases nullifies any promise that medical care costs will be met by *one and only one* increase in the Social Security tax. At the moment the plan is more academic than practical.

The snowball of cost starts small and grows larger and larger as it rolls down the mountain-side of our financial integrity till it strikes the bottom and shatters into myriad pieces, melts and dilutes the strength of our economy, like the last cup of coffee in a boarding-house.

Socialism is not equal distribution of wealth. It is equal distribution of poverty. Spartan simplicity is not our order.—F. F. Premuda, M.D., *Lake County Medical News*, March, 1961.

Abolishing Income Tax

A GREAT deal has been written concerning the proposed 23rd Amendment. Unfortunately, there is some confusion because there is a proposed amendment which has to do with citizens of Washington, D. C. voting in national elections.

Of course the next amendment to be ratified by two-thirds of the states will be the 23rd. I refer to one which pertains to the abolition of the Federal Income Tax—unfortunately, not many individuals know much about this bill, and hence are inclined to look on it as "crackpot

legislation," which, if enacted, would ruin the country. I would like to clarify some of the misconceptions and explain what the bill means.

It is officially designated as H.J. Res. 23, introduced by Mr. Utt in the House of Representatives, Jan. 7, 1959.

Section 1, which specifies that the government shall not engage in any business or individual enterprise except as specified in the Constitution of the United States, means that the government would not operate in competition to private enterprise. For example, the government now operates several large power companies which are in direct competition to privately-owned companies. The private companies are taxed at a high rate to pay for or offset the losses incurred by the government-operated utilities. The government is engaged in over 700 different enterprises, most of them operating at a loss and in direct competition to private corporations.

Section 2 declares that the Constitution or laws of any state shall not be subject to the terms of any foreign or domestic agreement which would abrogate this amendment. This merely means that foreign commitments would not be permitted to violate this amendment if it was passed.

Section 3 provides that the activities of the United States government, which violate the intent and purposes of this amendment, shall, within a period of three years from the date of the ratification of this amendment, be liquidated and the properties and facilities affected shall be sold. This means that these corporations and businesses would be sold to private individuals and corporations. If all of the government businesses were sold for \$50 billion (the assessed valuation is roughly \$200 billion) and this money applied to the national debt it would reduce the interest payments alone by \$1 $\frac{1}{3}$ billion a year.

Section 4 states that three years after the ratification of this amendment the sixteenth article of Amendments to the Constitution shall stand repealed, and thereafter Congress shall not levy taxes on personal income, estates or gifts. This is the part of the amendment that has received the most publicity and the part that frightens people who are not aware of our financial dilemma.

The first reaction is, how would the government operate if there were no income taxes? This can be very easily explained. As stated

above, the government is operating over 700 different enterprises; most all of them are losing money. In 1959 they operated at a loss of \$44 billion; in 1949, \$36 billion was collected from individual income taxes. Therefore, with no income taxes and no government businesses we would be \$8 billion ahead.

In addition to the above savings I would like to list some savings which are difficult to evaluate in terms of dollars and cents: save cost of collecting taxes \$200,000,000; save cost of printing tax forms, \$100,000,000; save cost of franked postage on tax mail, \$40,000,000; save cost of investigating officers, \$?; save cost of bookkeeping, \$?; *save our country from socialism*. Cost of operating our government would be met by corporation, excise taxes, etc.

Now, why should a doctor favor this amendment? It is because I am opposed to socialized medicine as I am opposed to socialism in general, and this is the best weapon I have seen to fight it. The Social Security Administration would no longer exist—the money paid into the fund would not be lost, it would be turned over to private carriers who in turn could give better coverage at a lower rate. It would be impossible to have government-controlled medicine if the government was not allowed to participate in any such activity.

I would hope that there are a few of you readers who will agree with what I have written, but probably none of you will take the time to let your views be known to your state association.

We and our country are in a deplorable financial state because too many of us have not shown any interest in what happens to government spending and waste. As taxpayers we are the government—let's do something about it.

I am sure that if any of you owned stock in a corporation that was operated as inefficiently as is our government that you would be writing letters to the board of directors. You ARE stockholders in the largest and best corporation in the world—let us do something about it.

There has been much talk of ways to boost our economy—if this amendment is passed it will give every wage earner a raise of 20%, and this money would be spent on goods and would thereby raise our economy without inflation.

I would like to see Indiana propose at the

next American Medical Association meeting that all state medical societies work toward adoption of this amendment and thereby thwart any further attempt at socialized medicine. This bill has already been ratified by four states: Louisi-

ana, Texas, Arizona and Wyoming. Let us hope that through our interest Indiana will be the fifth to ratify.

B. D. WAGONER
Union City, Ind.

Editorial Notes

Dr. F. E. Wrightman, President of the Kansas Medical Society, in a letter to the President of the Columbia Broadcasting System objected to the one-sided element of the television attack on the medical profession. He charged that one way to abridge the right of free speech would be to invite both sides of a discussion to assist in the preparation of what was purported to be complete coverage of both sides and then to exclude one side.

The summary paragraph of his letter reads as follows: "We heartily endorse the idea of public debate upon controversial issues but we believe an agency of the influence of the Columbia Broadcasting System should exercise exceptional care in the fair presentation of both sides of such issues. Particularly is this true where items of essential services are concerned because the public will elect how these are to be purchased. If their choice is made on less than full knowledge, the result can affect much more than the service in question.

"Therefore, we have not only a crisis to face but, due in part to this program, a dilemma in addition to our previous concern. Both the problem and the dilemma will react not only upon us as physicians but, we sincerely believe, shortly upon other essential services as well."

A gauge of the considerable (and increasing) desire of Americans for preventive medical care is provided by the initial report of the National Disease and Therapeutic Index. This statistical report is a service of Lea Associates of Flourtown, Pa., under the medical directorship of Dr. George Morris Piersol. In tabulating "Leading Diagnoses and Reasons for Patient Visits" it was determined that the diagnostic category "Special Conditions Without Sickness" was the leading diagnosis group in

1960. This group accounted for 1806 of every 10,000 visits to private physicians. Prophylactic inoculation and vaccinations were responsible for one-fifth of the 1806 visits. Prenatal care, without abnormal symptoms, was the second ranking diagnosis in the group with 382 patient visits per 10,000.

Dr. L. L. Fatherree, Director of the Illinois Department of Public Health, disclosed on Feb. 10, 1961 that out of a total of 3,645 T. B. beds available in 26 tuberculosis sanatoria in Illinois, 990 beds are now vacant. During 1960 there were 5,564 admissions and 5,709 discharges. The need for beds for the treatment of tuberculosis has declined in recent years not because there are fewer cases needing hospitalization but because new technics of chemotherapy and surgical procedures have reduced the average length of stay in a sanatorium from two years to less than nine months. (Illinois State Medical Society, Springfield, *Newsletter*)

Presidential Assistant, Arthur M. Schlesinger, Jr., speaking as a private citizen at Newton College of the Sacred Heart, is reported in the Congressional Record as stating that "a welfare state is the best defense against Communism." This is reminiscent of the sales pitch of a patent medicine company which advocated the use of its cathartic pills to cure the cathartic habit.

It is the same type of rationale which would attempt to sober a man by feeding him bourbon. Representative Pelly, in commenting on Mr. Schlesinger's remark, quoted Khrushchev (an undoubted authority on Communism) as declaring recently "small doses of socialism will eventually bring about Communism in America."

More than 65 new and revised fire safety standards will be considered at the annual meeting of the National Fire Protection Association. Technical committees have submitted proposals for standards in fields ranging from aviation and electronic computers to hospitals and service stations. The Committee on Hospitals will submit a new standard outlining minimum factors in the design and failure-proof operation of essential hospital electrical systems. The new standard has been developed in recognition of the increasing dependence on electrically-operated life-saving apparatus in hospitals. Revisions to the present code on flammable anesthetic agents will also be considered.

The Health Insurance Institute reports that 132 million Americans, 73% of the U. S. population, were covered by health insurance at the end of 1960. This is a new record and complements the record \$5.6 billion paid out in benefits last year, an increase of nine percent over 1959. There are now more than 1200 insuring organizations in the health field, including 737 insurance companies.

The Sears-Roebuck Foundation continues to assist in the building and equipment of medical centers in communities in need of a physician, but where a suitable building is not available. Communities applying for such aid are carefully screened to determine whether there is a potential to support a doctor. If such potential is evident the community is asked to conduct a financial drive for a fund of over \$35,000 for the construction. This places the citizens in partnership with the new doctor and insures community support for his practice. In Indiana an application has been received by the Foundation from Georgetown; Holland, Indiana has been certified for the fund raising drive.

Discussing smoking as a causative factor in lung cancer in the current (March 18) *Journal*

of the American Medical Association, Drs. Ernest L. Wynder and Emerson Day, Sloan-Kettering Institute for Cancer Research, New York City, said in part:

"The increase of cancer of the lung parallels the rise in cigarette consumption. The rates of lung cancer in most countries and the sale of cigarettes 30 years ago are consistent. The present sex ratio of lung cancer is consistent with the long-term smoking habits of the two sexes. Much of the difference in urban-rural frequency of lung cancer can be accounted for by differences in smoking habits."

"If one wishes to consider a constitutional factor as the alternative of the smoking factor, one has to consider that the factor, be it genetic, psychological, or whatever, has a similar magnitude, has changed during the last 30 years, differs from country to country, is sex linked, is more common in cities, increases with an increase in smoking, and is absent among such groups as the Seventh Day Adventists, who, because of their religion, are essentially nonsmokers and have exceedingly low rates of lung cancer."

Major teaching hospitals affiliated with medical schools filled 70% of their intern vacancies in 1953 and since then gradually improved to 83%. Minor affiliated hospitals have varied considerably in attracting interns with 38% in 1953, 65% in 1958 and 47% in 1960. The increases for teaching hospitals have been at the expense of non-teaching institutions. As a group they filled 31% of their vacancies in 1953 and have gradually fallen to 22% in 1960. As always training is more important than stipend. Since 1953 hospitals paying \$50 per month or less have slightly increased their intern classes, while hospitals paying \$50 and more (even up to over \$200) have experienced lower percentages of filling, with the higher paying internships attracting fewer than the medium priced jobs. Statistics are reported by the Association of American Medical Colleges from Internship Matching Program data.

Medicine

At

Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Suits filed alleging deaths of two children due to Chloromycetin—Two suits have been filed alleging two children died as a result of the administration of Chloromycetin. (A similar suit was reported in *The Citation*, Vol. 3, No. 7, p. 35.)

One of these suits was filed in the Alameda County Superior Court of Oakland, Calif. Parke Davis & Co., manufacturer of the drug, and the Piedmont Pharmacy, from whom the particular drug was purchased, were named as defendants. The plaintiffs seek \$250,000 damages for the wrongful death of their son and breach of warranty, plus \$3500 for hospital, medical, funeral costs and costs of the suit. The plaintiffs allege that their 20-year-old son was treated with Chloromycetin for acne and that the antibiotic caused a fatal blood disease known as aplastic anemia. The complaint states the drug manufacturer and the distributor violated their "implied warranty" that the drug was safe for human use. It is further charged that neither Parke Davis nor Piedmont warned of the hazardous properties of the drug.

Another suit was filed in the Circuit Court in Knoxville, Tennessee. The parents of a four-year-old girl who died following the administration of this drug seek \$300,000 damages against a Knoxville pediatrician and Parke Davis. The parents charge the manufacturer and the doctor with negligence in distributing and prescribing the drug.

An editorial entitled Chloramphenicol—A New Warning by Dr. William Dameshek, an authority on blood disorders, appeared in the Dec. 3, 1960 issue of *The Journal of the American Medical*

Association. Dr. Dameshek stated that chloramphenicol, which is made by Parke Davis under the trade name of Chloromycetin, may cause marrow aplasia. He believes that an increased incidence in aplastic anemia may result as the use of the drug increases. Dr. Dameshek makes a number of suggestions relative to minimizing this problem. One suggestion is:

"The patient and the patient's family must be warned, either by the physician or by the druggist that this is a powerful drug; that it should be used only once; that its repeated use may result in serious blood reactions; that it should not be kept in the bathroom cabinet and used again if an apparently similar disorder supervenes."

After the appearance of this article, George P. Larrick, the United States Food and Drug Commissioner, said the evidence is that chloramphenicol "saves more lives than it destroys" and therefore should not be banned from the market.

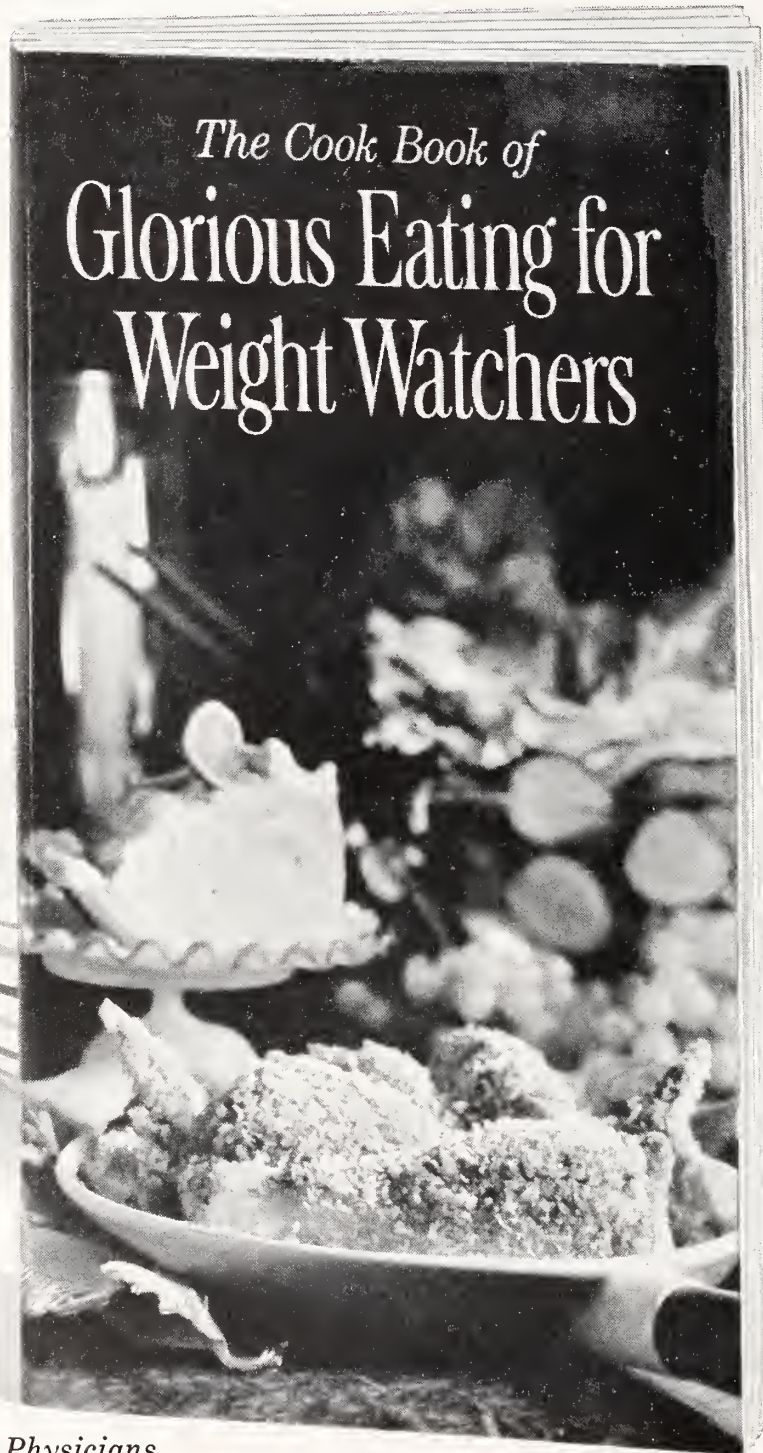
Two months ago, the California State Department of Public Health in Berkeley announced that it will investigate the drug because of its possible dangers.—*Aken v. Parke, Davis & Co., et al.*, Alameda County Superior Court, Oakland, California; *Caldwell v. Parke, Davis & Co., et. al.*, Circuit Court, Knoxville, Tenn., Jan. 25, 1961.

Plaintiff not entitled to have his attorney present during medical examination—The U.S. District Court for Maryland has held that a lawyer does not have the absolute right to be present whenever his client is examined by a doctor for the other side. However, the court

Continued on page 660

A REALISTIC AID TO PROPER WEIGHT MAINTENANCE

At Last...New Cook Book Designed



Free to Physicians

Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council

Prevent Overweight Through Better Eating Habits

Recipes and Menus with Satiety and Appetite Appeal in Mind

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to best weights by sex, age, size and extent of activity.

Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way is not a crash program. It offers calorie controlled menus with appetite appeal, variety and satiety in mind. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Not a reducing manual. It should be explained that "The Cook Book of Glorious Eating for Weight Watchers" is a guide to the *prevention of obesity*. Its publication marks the first time

that a food manufacturer like Wesson has taken so important a step to help combat this serious public health problem.

Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.

Note: Please do not confuse this booklet with the *Cholesterol Depressant Diet Book*, published by Wesson as an aid to physicians and for professional distribution only. The concept of the *Cholesterol Depressant Diet Book* stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.



The Wesson People, Dept. M, 210 Baronne St., New Orleans 12, La.

Please send me my copy of "The Cook Book of Glorious Eating for Weight Watchers", plus two dozen order blanks for distribution to my patients.

M.D.

ADDRESS

CITY, ZONE, STATE

Poly-unsaturated Wesson, the Pure Vegetable Oil, is Never Hydrogenated

stated that it would permit the attorney's client to have his own doctor present during the examination.

The court stated:

"Although I do not fully agree that an attorney has no ability to protect his client during an examination if the client needs protection, the decision . . . that a lawyer does not have the absolute right to be present whenever his client is examined by a doctor for the other side is sound, in line with the practice in this State and District. The presence of the lawyer for the party to be examined is not ordinarily either necessary or proper; it should be permitted only on application to the court showing good reason therefor. If the attorney desires to be present in order to control the examination, that would invade the province of the physician; if he desires his observations to be the basis of cross-examination or possible contradiction of the doctor, he is making himself in effect a witness, with the difficulties which are likely to arise when an attorney asks questions on cross-examination based upon his own observations, and the possibility that he may wish to take the stand and thereby disqualify himself from completing the trial as the attorney."—*Dziwanoski v. Ocean Carriers Corp.*, 29 U.S. L. Week, U.S.D.C. Md., Dec. 28, 1960.

In Reply . . .

Q. What is the legal status of medical students employed as externs in non-university hospitals?

A. It is not uncommon for medical students to obtain employment in non-teaching hospitals as a means of helping to finance their education. There is nothing *per se* illegal about the employ-

ment of medical students in such hospitals if their duties are confined to those commonly performed by persons who are not required to be licensed. To the extent that the medical student functions as an orderly or technician or in some similar capacity for which he is qualified, there is little cause for concern. However, there is serious reason for concern if the medical student is employed to perform the duties of a physician.

The fact that the medical student may be working in a hospital does not confer upon him the right to engage in the practice of medicine without a license; nor can a physician legally delegate to an unlicensed person the right to practice medicine. Since a medical student employed in a non-teaching hospital is strictly a lay employee, a physician who purports to delegate to a student the performance of duties constituting the practice of medicine is also in violation of the medical practice act.

A female who disrobes for a medical examination by an unlicensed person who has no authority to conduct such an examination may have a cause of action for damages if the circumstances are such that she is led to believe that the person conducting the examination is a doctor of medicine who has the legal authority to examine patients. The possibility of such action must be recognized, particularly in the case of private patients. Furthermore, malpractice insurance policies generally contain a clause which excludes coverage with respect to illegal acts.

Although care must be exercised even in teaching hospitals as to the degree of independent responsibility for patient care that is allowed to the student, the courts would probably distinguish between the duties performed by a student under physician direction and supervision as part of a teaching program, and the situation in which a student is employed to substitute for a licensed physician. ◀

A Model Family—Almost

During a period of six or seven years I confined one Victoria—bringing three babies. These were home deliveries. The day after the third child was born I remarked that the mother should have made her sweetheart marry her so that she would not have total care of her children. She replied, "But, Doctor, I was only an innocent young girl!"

Her mother, hearing the conversation, came in and said decisively, "I'm awful proud of my children. None of them either smokes or drinks."

—Submitted by Dr. Harvey Hadley, Richmond, Indiana

JACK W. HICKMAN, M.D.

Indianapolis

Fatalities in Migraine

The potentially fatal dangers of migraine are stressed in an article by Ask-Upmark,¹ who had previously estimated the frequency of migraine in females (apparently including many migraine variants) as 30%. Ophthalmoplegic migraine due to an aneurysm in the circle of Willis is mentioned, with the likely fatal results of rupture of such a vessel. A second associated or migraine equivalent phenomenon is paroxysmal atrial tachycardia, which admittedly is rarely fatal, but, as the author stresses, could be if improperly managed.

The same is true with the rare instances of bradycardia. Even though less frequent, this could more easily lend itself to a fatal iatrogenic condition if intravenous ergotamine tartrate were used for treatment of the headache. Use of the drug under these circumstances might easily induce complete heart block.

The fourth danger is that of interstitial nephritis or "phenacetin kidneys." The author noted eight such patients in his clinic in recent months, with one fatality. Apparently evidence as to renal toxicity from phenacetin is conflicting, but awareness of this possibility is justified. In summary, the author again stresses the point that the majority of these dangers are iatrogenic.

Weight Loss by Appetite Suppression and Diet

A report from Guy's Hospital shows the difficulty in evaluating any anorexogenic agent, as can be seen in similar reports in the past. This group evaluated Preludin as compared with a placebo, in 60 obese females over a period of two months. An interesting side note is that 28 patients did not complete the study, and the authors speculated that this might have been

due to a widespread bus strike at that time. Weight was checked every two weeks, and the patients were placed on 1,000 calorie diets. One group of patients was treated with the placebo for one month, and then Preludin for the second month, and this order was reversed in the second group. The first group had a greater weight loss (4.8 lb. as compared with 2.9 lb.). The dosage of Preludin was 25 mg t.i.d. in both groups. The second group actually had many who gained weight during their second month, i.e. when they were taking the placebo. The greater weight loss during Preludin therapy was statistically significant, but as has been seen in the past, most patients will lose some weight with any kind of short-term treatment, and there is also a hazard in expanding the results of an eight-week study to clinical practice, in which therapy must deal with changing eating patterns and over a period of years. Perhaps the conclusion that 50% of females ride busses in London is as good as any other.

Vitamin B-12 in Vegetarians

Comparison of serum vitamin B-12 levels in normal subjects and people who had been vegetarians for five to 25 years was done in Calcutta.³ Previous studies have shown the presence of anemia in the vegetarians with low B-12 levels, and presence of some neurologic changes. However the present study did not find cases of anemia or neuropathy. It did confirm the lower serum levels, however, with six of 10 patients having B-12 levels lower than the lowest value in the non-vegetarian group, i.e., below 98 micrograms per millilitre. One speculation that the authors raise is that intrinsic factor may play some role in the protection against neuropathy, since this was apparently normal in the vegetarians with low B-12 levels. The study also

GLEANED

Continued

confirmed the presence of an elevated B-12 level in patients with chronic myeloid leukemia, in both vegetarians and non-vegetarians.

Treatment of Rheumatic Fever

A report of the findings of a combined group of British and United States investigators on the value of various methods of rheumatic fever treatment is presented.⁴ The commission was set up in 1951-52 and has been evaluating ACTH, cortisone and aspirin in children with rheumatic fever since that time, so that 497 cases were available for comparison. Treatment of the initial attacks was for six weeks, and consisted of initial doses of either 80 units ACTH per day; 300 mg cortisone per day; or 60 mg per pound body weight of aspirin, with gradually decreasing doses of all the forms of treatment. Only 16 patients in the entire series (3.2%) died, and two of these were not from rheumatic fever. Perhaps the major conclusion of the study was that there was no evidence at the end of five years that one form of therapy was any better than any other in influencing prognosis. The major factor that appeared to influence prognosis was the status of the heart at the time treatment was begun. Patients without carditis at the beginning did well, since 96% showed no residual heart disease. This percentage decreased with severity of carditis present at the onset of the disease, so that only 30% of those with heart failure and/or pericarditis were found five years later to have no residual heart disease. Recurrences of rheumatic fever during the five years

of the study also had more severe cardiac conditions at the end of the study than those who had suffered no recurrences. It is stressed that treatments can not be properly evaluated unless the status of the heart at the beginning of the study is taken into account.

Fertility and Homosexuality

Short notice should probably be given to the report of Parr and Swyer⁵ which may be the first of its kind. The authors examined seminal fluid on 22 homosexual men to determine sperm count, motility, etc. Thirteen of the men were psychiatric and nine were not. The striking finding was that 10 of the 13 psychiatric patients were fertile or highly fertile, but only two of the non-psychiatric patients could be rated this well. The authors restrain themselves and do not let speculation run rampant as to explanations for these findings in this admittedly small series.

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625 E. 38th St.,
Indianapolis

About Our Cover

"Wanted alive . . ." will be words on the lips of many adults as schools close and young "sluggers" take to the outdoors via bicycle, skates, foot and any conceivable mechanism the young mind chooses to invent. We are reminded again this year that youngsters depend on motorists to watch for them, read their minds, anticipate their every move.

Our cover idea for May came from a poster published by the National Professional Driver Education Association, Inc., Chicago. The Journal is indeed indebted to this group for their kind permission to reproduce parts of this poster.

THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

ESTABLISHED 1873

*A Private Psychiatric Hospital Offering
Modern Diagnostic and Treatment Procedures*

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

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Camp for Diabetic Children

Sponsored by Indianapolis Diabetes Association at
Camp James Whitcomb Riley

DIABETIC CHILDREN ages eight to 16 have an opportunity to spend almost three weeks camping in Bradford Woods this summer, with highly specialized facilities available at all times.

Developed by the Riley Memorial Association and Indiana University, the seventh annual camp session of Camp James Whitcomb Riley will open Sunday, July 30.

Bradford Woods, a tract of 2300 acres in the scenic hills of Morgan County, southwest of Indianapolis, was given to Riley Hospital for Children by the late John Bradford. Under the direction of the University and Riley Memorial, Bradford Woods is developing into a statewide camping center exclusively for children and students.

It is a winterized facility, featuring a spacious dining and recreation hall, modern infirmary, swimming pool, craft shop, library and dormitory cottages. A 110-acre lake which will serve

the area is now under construction. Built in keeping with the Riley policy of providing opportunity for youngsters who might not otherwise get to go to camp, it has proven well suited for diabetic youngsters.

Bradford Woods is located on Highway 67, 26 miles southwest of Indianapolis and six miles north of Martinsville, Ind. Entrance signs are on the highway.

Director Has Wide Experience

Mr. Cliff Weisheit and his staff will again direct the activities of the camp. Mr. Weisheit has had wide experience in camp counseling and his assistants have been chosen on the basis of character, personality, and training. A well-rounded and instructive program has been arranged by this group. The program will be conducted on a non-sectarian basis without restrictions as to race or creed.

Campers themselves will plan their own programs in each group, with the help of counselors.

Each day may be entirely different. There will be hikes to the creek, with its hundreds of adventures around every bend, in each pool with its clear water, in its many wading places on the shallow rock stream bed.

There will be crafts of many kinds, nature study of animals, birds, trees, rocks, star-gazing, campfires, dramatics, story-telling, painting and sketching, writing, creative music, outdoor cooking, nature games, sports (i.e., baseball, volleyball, badminton, archery, etc.), planning church and vesper services, wood camp construction, woodcraft, reading and many others.

Constant Medical Care

Children in the camp will be under constant medical and nursing care. Resident physicians and nurses are on duty during the entire period and members of the clinical group of the Indianapolis Diabetes Association visit the camp daily for consultation with resident physicians. Dieticians will supervise the dietary needs of the campers. All medical activities will be under the direct supervision of the Indianapolis Diabetes Association. Equipment will be available for all necessary tests incident to the control of diabetes in well-equipped laboratories. Medical care will be ample in the camp, including infirmary provisions. Indianapolis is near and there are ample hospital facilities in case of an emergency.

Requirements

Children accepted for camp must have had at least the first two injections of poliomyelitis vaccine, tetanus toxoid or a booster shot within the past two years and smallpox vaccination within the preceding five years.

The fee for the three weeks is \$150.00. Twenty-five (\$25.00) dollars is payable at time of application and the remainder before camp opens or on opening day. This fee includes all diabetic supplies and the necessary laboratory procedures to maintain good diabetic control. There are funds available for financial assistance to children whose families are unable to pay the full amount. Information on request regarding partial camperships. The Association receives help from the United Fund of Greater Indianapolis, Inc., which allows them to take a number of children who would otherwise not have the experience of attending camp.

Campers will be accepted only for the full three weeks, since the child will not obtain the

maximum benefit in a shorter period. If a camper leaves during the camp period for reasons other than those approved by director or physician, no money will be refunded.

About one dollar a week should be sufficient for small purchases as stamps, cards, etc., from the commissary. A camp bank will be set up. Campers are directed not to bring candy, or any other form of food, with them.

The association carries a camper's insurance on each child, which insures the child from the time he leaves home for camp until he returns home.

Stated fee does not defray the full cost of providing this camping experience nor does it cover any capital requirements. A trust fund known as "The Indiana Diabetes Foundation" has been established by the Indianapolis Diabetes Association, Inc., and the American-Fletcher National Bank and Trust Company of Indianapolis is designated to receive gifts for the permanent use of the camp. Further details concerning the Foundation may be obtained from Indianapolis Diabetes Association, Inc. or the American-Fletcher National Bank and Trust Company of Indianapolis.

In addition to offering these children an unusual opportunity for camping experience, the program has been planned to teach the campers greater self-reliance in the handling of their diabetes. As the children associate with other diabetic children, they lose the feeling of being "alone." Mental acceptance of control after just one session in camp is remarkable. Medical staff members associate with the campers in their activities—half-hour sessions of instructions regarding care are scheduled for small groups during rest periods.

Several children have attended camp every year since it was established in 1955; many have returned as senior campers and counselors. The high percentage of repeat campers attests to the acceptance by campers because they have "FUN" and by parents and physicians because of the good medical and dietary care.

Information or application forms may be obtained from:

Indianapolis Diabetes Association, Inc.
821 Hume Mansur Building
Indianapolis 4, Indiana
Telephone: MEIrose 9-1111

Limited capacity requires prompt attention. Applications close July 1, 1961. ◀



AMERICA'S FRONT DOOR— New York City—will present this glistening and glamorous facade of welcome to the nation's physicians, their families and their guests when the American Medical Association holds its 110th Annual Meeting there next June 25-30.

AMA to Stage Big 'World's Fair' At New York June Meeting

The American Medical Association's 110th annual meeting, the "world's fair of medicine," will bring an estimated 50,000 persons, including 25,000 physicians, into New York City, June 25-30.

The five-day convention, biggest of its kind in the world, will attract not only doctors, but also their wives and families as well as residents, interns, exhibitors; in fact, people connected with all the allied fields of medicine. Hence, the convention theme: "Teamwork in Medicine."

The 1961 meeting will mark the eighth time that the AMA has met in New York. The last convention there was in 1957 when 23,888 physicians registered.

Technical exhibits, numbering 827 and displaying everything from medical books to diapers, and more than 350 scientific exhibits, largely developed, designed and manned by physicians reporting their research, will take up practically every inch of space on all four floors of New York's big Coliseum.

More than 2,000 physicians will take part in the scientific program, which is designed to keep doctors abreast of what's new in medicine.

Teaching mediums will include lectures, symposiums, panel discussions, movies and closed-circuit television.

More than 300 physicians will deliver lectures before 20 different section meetings. Each section represents a specialty in medicine. The section meetings, which run simultaneously, will be held not only in the Coliseum, but also in nearby hotels.

Program on Chest Diseases

A highlight of the scientific program will be a one-day meeting on Monday, sponsored jointly by the AMA and the American College of Chest Physicians. This program, planned by Dr. Coleman B. Rabin, New York, secretary of the AMA Section on Diseases of the Chest, in cooperation with Dr. Herman Moersch, Rochester, Minn., director of medical education and research of the American College of Chest Physicians, will consist of symposiums, panel discussions, reading of scientific papers, roundtable luncheon meetings and fireside conferences, where physicians gather to discuss medical problems of the chest informally. The American College of Chest Physicians is holding its 27th annual meeting in New York, June 22-26, just prior to the AMA session.

On Tuesday, the AMA will sponsor for the first time a research forum. Participants will represent a cross-section of every medical specialty. The forum program, representing six

authors believe that at the first "appendectomy" an acutely inflamed cecal diverticulum or an appendix epiploica was mistaken for the appendix vermiformis.

In the other seven patients the following diagnoses were made, mostly on the basis of pathologic studies: (1) acute inflammation of the proximal appendiceal stump; (2) acute appendicitis in an appendiceal tip; (3) acute gangrene of a solitary diverticulum of the cecum; (4) chronic cholecystitis with cholelithiasis, cholesterosis of the gallbladder, and chronic Meckel's diverticulitis; (5) a segmental type of ileitis; (6) acute pyelonephritis in an ectopic kidney; and (7) torsion of the omentum. In this last instance the diagnosis was not established by laparotomy, but the clinical picture was highly suggestive of this entity. The presence of right-sided abdominal pain without a change in bowel habits, nausea or vomiting, without fever and with a palpable mass, are all associated with omental torsion, which occurs most frequently in robust males who are exposed to abdominal trauma or strenuous physical exertion.

Cahan, J., Horwitz, A.: Acute Right Lower Abdominal Pain with Past History of Appendectomy. *Am. Surg.* 26:460, July, 1960.

DILATATION OF THE COLON

The authors report on 16 patients with ulcerative colitis who were admitted to the Mount Sinai Hospital, New York, and in whom a rapidly developing and striking dilatation of the colon was associated with extreme toxicity. In 13 of the 16 patients the dilatation complicated an acute exacerbation of the disease. All patients were febrile, toxic, and dehydrated. Most had tachycardia, anemia, and moderate to severe depression. A simple abdominal roentgenogram was usually diagnostic and revealed marked colonic dilatation, most pronounced in the transverse colon and sparing the rectum. Deep, undermining ulcers were seen by air contrast. Pathologically, involvement of all elements of the colon with inflammatory changes was striking. Perforation was observed in four patients. There were three deaths, a mortality of 19%. Nine patients required emergency surgical intervention. Six were treated by ileostomy and subtotal colectomy, with one operative death, and 3 prolonged, stormy courses. Three patients were treated with decompressing cecostomy, all with resulting improvement.

The authors emphasize that the results of this approach were so favorable as to demand further trial in these specific circumstances. Twelve patients were treated with ACTH or adrenal steroids coincident with the colonic distention, and in some of them the beneficial or detrimental results were clearly evident. Recommendations for future management include the administration of ACTH and adrenal corticoids, long tube intubation, and decompressing cecostomy.

Korelitz, B. I., Janowitz, H. D.: Dilatation of the Colon. *Ann. Internal Med.* 53:153, July, 1960. ◀



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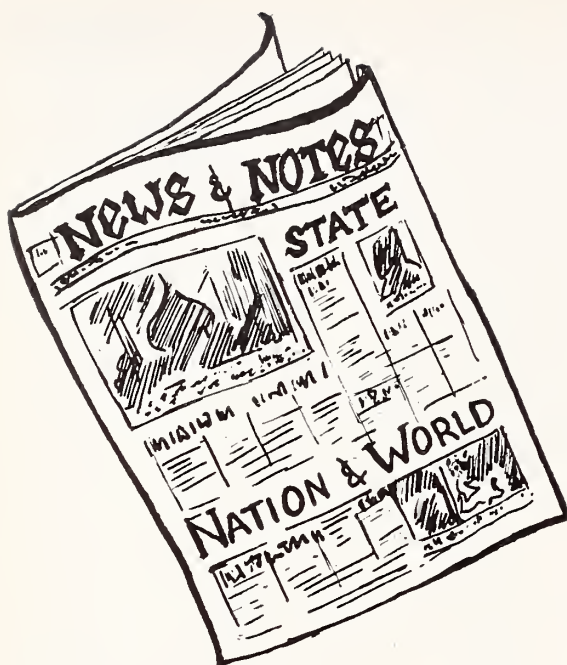
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PDW-11



Doctors Invited to Submit Papers For AMA Chicago Meeting in 1962

The Council on Scientific Assembly invites physicians to submit titles and brief abstracts of scientific papers they wish to deliver at the 1962 annual meeting of the American Medical Association, which will be held in Chicago, June 11-15. The deadline is Oct. 15.

"We would like to receive as many titles and abstracts as possible," said Council Chairman Samuel P. Newman, of Denver, "because in that way we have better selection and this, in turn, assures a more timely and better scientific program."

Dr. Newman urged physicians to contact members of the council in their own regions and discuss prospective papers with them.

Besides Dr. Newman, members of the council are Drs. J. Arnold Bargen, Temple, Tex.; Gilson Colby Engel, Philadelphia; Lee Edward Farr, Upton, N. Y.; John B. Hickam, Indianapolis; Fay A. LeFevre, Cleveland; Carl A. Lincke, Carrollton, Ohio; Alphonse McMahon, St. Louis, and Walter Scott, Los Angeles.

The nine-member council, one of the oldest in the AMA organization, is responsible for the scientific program at both the annual and clinical meetings. Its job is prodigious. More than 2,000 physicians take part in the annual convention

program. At the New York session in June, for example, more than 300 physicians will deliver lectures before 21 different section meetings. Each section represents a specialty in medicine. These programs are designed to keep doctors abreast of what's new in medicine. Teaching mediums include lectures, symposiums, panel discussions, movies and closed-circuit television. A similar scientific program, but on a smaller scale, is sponsored at the AMA clinical meetings, which are held annually in December.

The AMA meeting in '62 will be held in Chicago's new \$35,000,000 exposition center on Lake Michigan, which has 300,000 square feet of exhibit space alone.

Physicians who wish to participate in the Chicago scientific program and desire information are invited to write to Dr. Charles Bramlitt, Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10, or to any council member.

August 1 is the deadline for applications for certification in the American Board of Obstetrics and Gynecology Part 1 examinations. Current bulletins outlining requirements may be obtained from the secretary, Robert L. Faulkner, American Board of Obstetrics and Gynecology, 2105 Adelbert Rd., Cleveland 6, Ohio.

Status of Hill-Burton grants for Indiana as of Feb. 28 showed 68 projects, costing \$72,862,-202, including a federal contribution of \$23,-828,304 and supplying 3,166 additional beds completed and in operation. The Department of Health, Education and Welfare also reported on 29 projects under construction. These will cost \$35,008,108, including a \$9,077,335 federal share, and will supply 1,233 additional beds.

Two Indianapolis Physicians Receive Cancer Society Grants

Two Indianapolis doctors are recipients of a total \$3,100 in grants from the American Cancer Society, New York. Dr. James A. Green, I.U. School of Medicine, was voted \$800 for design and building of a device to trim out the extremely small specimens for microscopy.

A grant of \$2,500 was awarded to Dr. Richard W. Dyke, Marion County General Hospital, to establish a special laboratory for teaching and investigation of leukemia and other blood abnormalities.

Veteran Evansville Doctor Enters Semiretirement

Dr. Robert W. Viehe, veteran Evansville physician, entered semiretirement in March after practicing in the same office since 1910. He will continue making house calls and doing hospital work, but does not plan to hold office hours.

Lilly Official Appointed to A.P.A. Post

W. Brooks Fortune, Ph.D. of Indianapolis, Executive Director of Biochemical and Biologic Production for Eli Lilly Company has been appointed to the executive committee on the National Formulary by the American Pharmaceutical Association Council.

Dr. Craft Speaker at National Meeting

Dr. Kenneth L. Craft, Indianapolis, attended the recent meeting of the American College of Allergists at Dallas, Texas, and presented a paper before the EENT Section upon "The Relation of Allergic Disease to Otology."

An Indianapolis dermatologist, Dr. James M. Gosman, was awarded a National Distinguished Service Award and Bronze Medal at a state meeting of the American Cancer Society Hoosier Volunteers.

I.U. Junior Receives Grant For Travel to West Africa

Alan E. Beer, a member of the junior class of Indiana University School of Medicine has received a Smith, Kline & French grant which will permit him and his wife, a registered nurse and anesthetist, to spend 11 weeks at the Sudan Interior Mission Eye Hospital at Kano, Nigeria and at General Hospital of S.I.M. at Egbe, Nigeria, West Africa. Thirty junior and senior medical students from across the nation received grants this year, four women and 26 men. In addition eight of the Fellows will be accompanied by their wives who are professionally qualified and accepted to participate in the program; 29 students worked and studied in foreign countries in 1960. The program will be continued through 1962.

Purdue to Receive Grant From Public Health Service

The Public Health Service recently announced the award of 35 grants for graduate training in public health totaling \$824,600, to 24 schools in 15 states and Puerto Rico. Purdue University will receive \$41,040 for research in microbiology and analytical chemistry by its School of Civil Engineering. ◀

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FUTURE MEETINGS, SEMINARS, COURSES

COLLEGE OF CHEST PHYSICIANS PLANS JUNE MEETING

The 27th Annual Meeting of the American College of Chest Physicians will be held at the Commodore Hotel, New York City, June 22 to 26. Scientific sessions start on June 24. On June 26 the College will hold a joint scientific session with the Section on Diseases of the Chest of the AMA. Dr. Charles Alvey of Muncie and Drs. Arvine Popplewell and John V. Thompson of Indianapolis will participate in the College program.

Trudeau School Plans Session For June at Saranac Lake, N. Y.

The Trudeau School of Tuberculosis and Other Pulmonary Diseases will hold its 46th session in Saranac Lake, N.Y., June 5-23. An annual postgraduate course for physicians, it is conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation.

Tuition is \$100 for a three weeks session. The course is a thorough review for specialization in pulmonary disease or for work in public health involving tuberculosis.

Early applications are encouraged, since enrollment is limited. Inquiries may be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, N. Y.

Meeting to be in Cincinnati

May 21-25 are the dates for the annual joint meeting of the National Tuberculosis Association, American Thoracic Society and National Conference of Tuberculosis Workers. Headquarters will be the Netherland Hilton Hotel, where scientific sessions will be held and exhibits displayed.

Dr. John B. Hickam, Indianapolis, will appear on a panel, "Pulmonary Hypertension," Monday, May 22.

DIABETES ASSOCIATION TO CONVENE

Members of the American Diabetes Association will meet at the Commodore Hotel, New York City, June 24-25. Inquiries may be addressed to the executive director, Mr. J. Richard Connelly, 1 E. 45th St., New York 17.

Neurologists Choose Atlantic City

The American Neurological Association will meet at the Hotel Claridge, Atlantic City, June 12-14. Information may be obtained from Dr. Melvin D. Yahr, Neurological Institute, 710 W. 168th St., New York 32.

New England Surgeons Plan Cape Cod Meeting

The New England regional meeting of the International College of Surgeons is scheduled for July 1-4 at Chatham Bars Inn, Chatham, Cape Cod, Mass. Further information may be obtained from Dr. M. Leopold Brodny, 4646 N. Marine Dr., Chicago 40.

Thirteenth Pathology Seminar May 21 in Indianapolis

The Indiana Association of Pathologists will present its thirteenth annual seminar, in co-sponsorship with the U.S. Veterans Administration Hospital, May 21 at the V.A. Hospital Auditorium, Indianapolis.

Dr. David C. Dahlin, Mayo Clinic, will present the scientific program, "Tumors of the Skeletal System."

Some slide sets protocols and x-ray duplications are available for pathologists who are not members of the Association and who wish to attend. They will be issued to those who apply, in the order of receipt of application.

A check for \$10.00, made out to the Association, should be sent, together with the request, to Dr. Edwin E. Pontius, Methodist Hospital, Indianapolis 7.

All MD's are invited to attend, whether or not they obtain the study sets. Presentation will be by lantern slide projections. ◀

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References: 1. Freedman, A. M.: *Pediat. Clin. North America* 5:573 (Aug.) 1958. 2. Nathan, L. A., and Andelman, M. B.: *Illinois M. J.* 112:171 (Oct.) 1957. 3. Santos, I. M. H., and Unger, L.: *Ann. Allergy* 18:179 (Feb.) 1960. 4. Litchfield, H. R.: *New York J. Med.* 60:518 (Feb. 15) 1960.

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Deaths

William F. Allison, M.D.

A retired Indianapolis physician, Dr. William F. Allison, passed away March 15 at the age of 79.

A graduate of Louisville University College of Medicine, Dr. Allison was assistant medical examiner for Pennsylvania Railroad from 1922-40. He had been retired for 20 years.

Samuel Wesley Boren, M.D.

Dr. Samuel W. Boren, 93-year-old retired Poseyville physician and civic leader, passed away March 22. He had maintained practice in Poseyville from 1902 until entering semi-retirement about 13 years ago.

A 50-Year-Club ISMA member, Dr. Boren was a graduate of Jefferson Medical College, Philadelphia, Pa. He was active in the Poseyville Chamber of Commerce and was three times Worshipful Master of his lodge.

Harry Lewis Brooks, M.D.

Dr. Harry Lewis Brooks, 67, a Michigan City ophthalmologist since 1921, passed away March 14.

He was a founder of the Doctors Hospital in Michigan City, which he and a group of physicians started in 1921.

A graduate of the Hahnemann Medical College, Class of 1918, Dr. Brooks served in World War I. He was a fellow of the American and International Colleges of Surgeons.

Norman R. Cook, M.D.

A Richmond psychiatrist, Dr. Norman R. Cook, passed away suddenly March 30 at the age of 55.

Dr. Cook had practiced at Richmond since 1948, coming there from service in the U.S. Army Medical Corps.

A graduate of Butler University and the I.U. School of Medicine, Dr. Cook served as assistant medical director of Marion County General Hospital in 1945.

Harvey B. Decker, M.D.

Dr. Harvey B. Decker, Terre Haute general practitioner and urologist, passed away Feb. 21 at the age of 71.

A graduate of the I.U. School of Medicine in 1919, Dr. Decker had practiced in Terre Haute for 40 years.

Carl Habich, M.D.

Dr. Carl Habich, former chairman of the Department of Gynecology at Indiana University School of Medicine, passed away March 16 at the age of 73.

Dr. Habich had practiced medicine since 1909, and following service in the Army Medical Corps during World War I, became a gynecologist. He was a graduate of the I.U. School of Medicine and Johns Hopkins University. In the 1930's he served as chief of staff at St. Vincent's Hospital in Indianapolis.

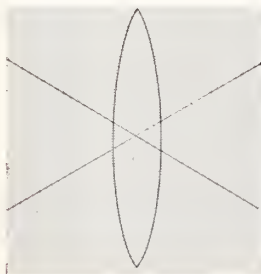
Kenneth I. Jeffries, M.D.

Dr. Kenneth I. Jeffries, Indianapolis physician from 1907-1955, passed away March 3 at the age of 81.

A 1903 graduate of the Indiana University School of Medicine, Dr. Jeffries was well known as one of south Indianapolis' oldest physicians, before his retirement six years ago. He was a member of the Masonic lodge, Scottish Rite and Shrine.

Walter F. Kelly, M.D.

Dr. Walter F. Kelly, Indianapolis physician for more than 54 years, passed away March 1 in his home at the age of 87.



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A 1906 graduate of Indiana Medical College, he was a former athletic director of the University of Texas, and then served in that capacity at the former Butler College. He began medical school after five years of coaching at Butler.

Dr. Kelly was at one time president of the Marion County Medical Society and served as chairman of its constitution and bylaws committee for many years. He served as senator from Indianapolis in the 1949-51 General Assembly.

Robert H. Lowe

Word has been received of the death March 18 of Dr. Robert H. Lowe, 56, former superintendent of Marion County General Hospital from 1955-56.

At the time of his death he was director of medical education at Lima, Ohio, Memorial Hospital.

Leonard K. McMurtry, M.D.

A former Evansville physician, Dr. L. K. McMurtry, passed away Feb. 28 at University City, Mo., at the age of 67. At the time of his death he was chief surgeon at Wabash Railroad Hospital, Moberly, Mo.

Dr. McMurtry practiced in Evansville from 1933 to 1949. He was a graduate of the I.U. School of Medicine.

James L. Wyatt Sr., M.D.

A former president of the Allen County Medical Society, Dr. James L. Wyatt, passed away Feb. 27 at the age of 67.

A graduate of the I.U. School of Medicine, Class of 1923, Dr. Wyatt was instrumental in creating the present system of care for Indiana's indigent sick. ◀

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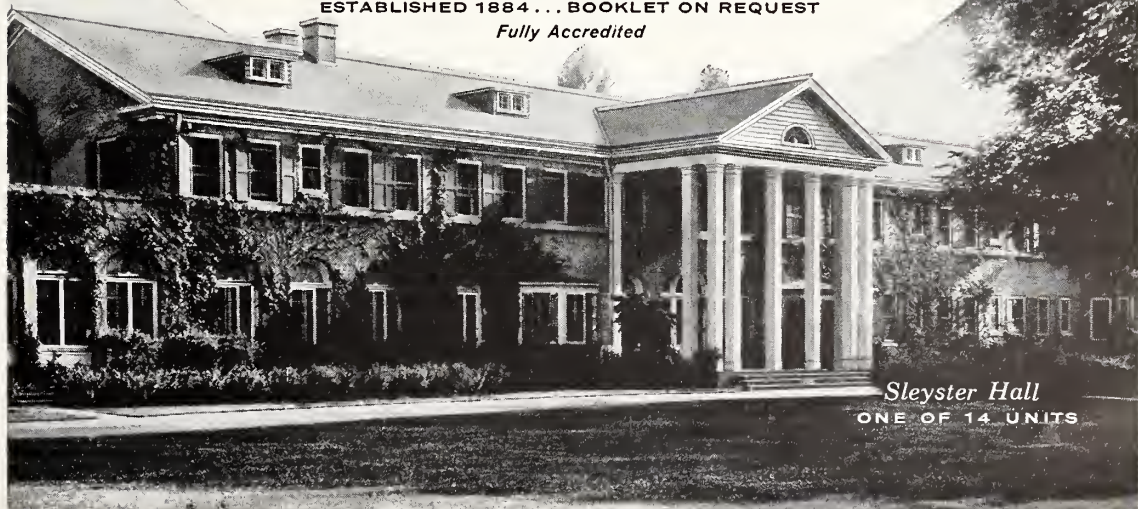
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County Society News

Allen

Dr. Richard W. Stander, assistant professor of obstetrics and gynecology at Indiana University School of Medicine, spoke on "Current Uses of the Synthetic Progestational Agents" at the Mar. 7 meeting of the Allen County Medical Society. Seventy members attended.

Bartholomew-Brown

Thirty members of the Bartholomew-Brown Medical Society heard a talk on the Red Cross Fund drive at the Mar. 8 meeting in Columbus.

Benton

Dr. A. L. Coddens is the new president of the Benton County Medical Society. Assisting him is Dr. D. L. McKinney, secretary-treasurer.

The group participated recently in the local cancer society's pap smear program.

Carroll

Dr. Charles L. Wise gave a travelogue for members of the Carroll County Medical Society and their office personnel Mar. 15 at Delphi. There were 40 members and guests present.

Cass

Twenty-three members of the Cass County Medical Society heard a speaker discuss T.B. and other diseases in Dutch New Guinea at their Feb. 7 meeting.

Clark

Twenty-six members of the Clark County Medical Society met at Henryville Mar. 21 for a general business meeting.

Clay

Seven members and two guests heard a representative of the Brazil Chamber of Commerce discuss their community promotion program at the Mar. 21 meeting of the Clay County Medical Society in Brazil.

Decatur

Dr. Joe M. Black, Seymour, spoke on "The Legislative Status of the Medical Profession" at the Mar. 21 meeting of the Decatur County Medical Society. Nine members attended.

Delaware-Blackford

Officers of the Delaware-Blackford Medical Society for 1961 include Drs. Stanley Burwell, president; Fletcher McDowell, president-elect; Leland Brown, secretary and Hugh Tomlin, treasurer.

Serving on the Executive Committee will be Drs. Guy Owsley, George McCoy, Joseph Clevenger, Stewart Brown, Clyde Botkin and Paul Burns.

The Board of Censors includes Drs. Dean Jackson, Hugh Tomlin and Herbert Ware.

Delegates to state convention are Drs. Thomas Brown, Gynn Rivers and Dean Jackson; their alternates include Drs. Edward Wierzalis, Charles Alvey and Donald Taylor.

Floyd

Twenty-two members of the Floyd County Medical Society met at New Albany March 10 for a general business discussion.

Lake

Dr. R. S. Griffith of the Indiana University School of Medicine discussed "Newer Concepts of Erythromycines" at the March 8 joint meeting of the Lake County Medical Society and Northwest Dental Association.

Montgomery

Members of the Montgomery County Medical Society heard a discussion and report on communicable disease at their Mar. 16 meeting. Twenty doctors attended.

Continued

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PDW-12



COUNTY NEWS

Continued

Orange

Members of the Orange County Medical Society have plans to participate in the county cancer detection clinic this spring, and are also taking part in a grade-school "roundup" day for immunizing children.

Perry

Dr. Fred Smith spoke on "Hemolytic Anemia" at the March 7 meeting of the Perry County Medical Society. Six members and one guest attended.

Putnam

Dr. James B. Johnson gave a "Summary of Postgraduate Courses at I.U." at the March 10 meeting of the Putnam County Medical Society.

Hamilton

Hamilton County Medical Society officers for 1961 include Drs. Ray Shanks, president; John Haywood, vice president, and Paul Waitt, secretary.

Washington

Newly-elected officers of the Washington County Medical Society are Drs. H. G. Coleman,



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Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he can do about anything an ordinary person can do. Hanger Arms are custom-made to fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand and hook.

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president; E. R. Apple, vice president; and W. T. Paynter, secretary-treasurer.

Vanderburgh

Members of the Vanderburgh County Medical Society saw a sound film of a closed circuit television symposium on clinical experience with and practical technics for use of Norethynodrel at their April 11 meeting. The program was originally sponsored by G. D. Searle & Co.

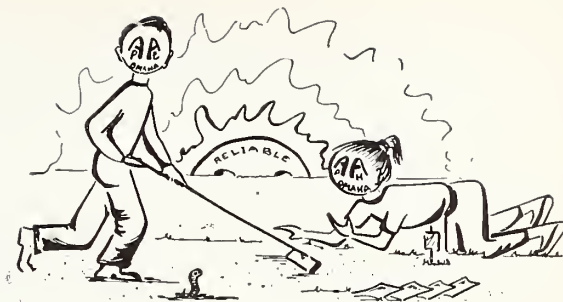
Wayne-Union

Dr. Harold King, of the I. U. School of Medicine, spoke on "Aortic Aneurysms" at the March 14 meeting of the Wayne-Union Medical Society. There were 49 members present.

Wells

Dr. Clyde Culbertson, of Eli Lilly and Co., spoke on "Use of Tissue Culture in Virus and Cancer Research" at the March 20 meeting of the Wells County Medical Society at Bluffton. Nineteen members attended.

Dr. Arthur L. Drew, of the Department of Neurology, I.U. School of Medicine, spoke at their April 19 meeting. ◀



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FORMULA —

Each 5 cc. (one teaspoonful) contains:	
Iron (as Ferrus Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.
In an exceptionally pleasant tasting base.	

**The FIRST Hematinic to Contain
BOTH CHELATED IRON and CHE-
LATED MINERALS Assuring a
Truly Flavorful, Better Tolerated
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LIQUID HEMATINIC
**CHELATED IRON-MINERALS
and VITAMINS**

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**DETROIT 34,
MICHIGAN**



demonstrating..



1 place the foam in your hand (one applicator full). Note the volume . . . plenty for an effective block.

2 cup your hand. Rub the foam into the creases which simulate folds of vagina and cervical os. After extended rubbing . . . note how it becomes heavy and creamy . . . how it covers and blocks.

INDIANA STATE BOARD OF HEALTH

Monthly Report—March, 1961

Disease	Mar. 1961	Feb. 1961	Jan. 1961	Mar. 1960	Mar. 1959
Animal Bites	536	334	212	340	378
Chickenpox	1138	897	693	885	915
Conjunctivitis	136	150	61	190	110
Diphtheria	0	0	0	1	0
Dysentery, Unspecified	23	94	12	121	13
Impetigo	92	88	62	70	65
Infectious Hepatitis	366	234	123	143	34
Infectious Mononucleosis	39	14	35	23	18
Influenza	823	495	584	3720	10674
Measles (Rubeola-Rubella)	1065	835	562	1835	843
Meningitis, Meningococcal	2	2	2	3	5
Meningitis, Other	10	2	2	6	9
Mumps	1101	469	343	600	362
Pertussis	16	9	12	28	108
Pneumonia	229	237	196	286	196
Poliomyelitis	1	0	0	1	0
Streptococcal Infections	1156	874	541	1501	1536
Tinea Capitis	12	27	7	19	20

WANTED

Continued

Locations

Carroll County—FLORA—population 1,800 with a large surrounding territory. Rich farming community with five factories. Located 21 miles from Logansport and Kokomo, where hospital facilities are available. Community willing to help financially. Office space available. Contact Mr. C. W. Ryan, 8 E. Main St., or Max Adams, Flora, for details.

Fayette County—CONNERSVILLE—Population 18,000. Need two general practitioners and an eye, ear, nose and throat physician. Several manufacturing concerns located there. Hospital facilities available. Contact J. L. Steinem, M.D., 812 Grand Ave., or Mr. W. S. Moellerling, 631 Central Ave., Connerville, for details.

Owen County—SPENCER—population 3,000. Located 45 miles southwest of Indianapolis and 17 miles from Bloomington, home of Indiana University, where hospital facilities are available. A Sears Foundation medical unit will be completed in June 1961. This is a two-doctor unit which will be available for rent, lease or purchase with terms suitable to the doctor. Contact Mr. Wade Allbritten, 635 W. Hillside Ave., and Mr. Charles Uhle, 311 Lovers Lane, Spencer, Ind., for details. ◀

COOK COUNTY GRADUATE SCHOOL OF MEDICINE INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SPRING-SUMMER, 1961

General Surgery, One Week, May 8
Surgical Technic, Two Weeks, June 5
Surgery of Colon & Rectum, One Week, June 5
Gallbladder Surgery, Three Days, June 19
Surgery of Hernio, Three Days, June 22
Advanced Electrocardiography, One Week, June 19
Gynecology, Office & Operative, Two Weeks, June 12
Vaginal Approach to Pelvic Surgery, One Week, May 15
Practical Cystoscopy, Ten Days, by appointment
General Practice Review, One Week, May 22
Neuromuscular Diseases of Children, Two Weeks, June 12
Fractures & Traumatic Surgery, Two Weeks, June 12
Thoracic Surgery, One Week, June 19
Blood Vessel Surgery, One Week, May 15
Breast & Thyroid Surgery, One Week, May 22
Hematology, One Week, June 12

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:

REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Association News

EXECUTIVE COMMITTEE

January 14, 1961

Roll call showed the following present: Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Hollowell and Ralph Hamill, attorneys; James A. Waggener, executive secretary.

Membership Report

The membership report for December, 1960, was approved by consent.

Number of members as of Dec. 31, 1959-----4,257

1960 members as of Dec. 31, 1960:

Full dues paying -----3,631 (includes 24 new members at \$30.00)

Interns ----- 34

Residents ----- 173

Council remitted ----- 44

Senior ----- 389

Military ----- 35

Honorary ----- 1

Total 1960 members as of Dec. 31, 1960-----4,307

Gain over last year----- 50

Number of members as of Dec. 31, 1959-----4,257

Delinquent members as of Dec. 31, 1960----- 13

Number of AMA members as of Dec. 31, 1959--4,120

1960 AMA members: Dues paying-----3,486

Exempt, but active- 679

Total 1960 AMA members as of Dec. 31, 1960 4,165

Gain over last year----- 45

Delinquent AMA members as of Dec. 31, 1960-- 17

(The above paid 1959 AMA dues but not 1960)

Number who have paid state dues but not AMA dues in 1960----- 126

The report on dues collection was accepted by consent.

Treasurer's Office

Statements of Income and Expenses and Investment Account for December, 1960, were approved by consent.

The matter of employment of an investment counselor for the Association was tabled by consent.

Legislation

Local: The secretary and attorneys discussed the Professional Corporation Bill and upon motion of Drs. Glock and Stimson the Executive Committee is to recommend to the Council that the Association not support this measure.

The secretary reviewed the bills listed in the Hospital News Letter which the Hospital Association is proposing to have introduced in the General Assembly. The secretary was instructed to inquire as to the position of

the American Medical Association concerning the legality of blood as a service rather than a product.

National: The president read a letter from Dr. E. Vincent Askey, president of the American Medical Association, concerning the effort which organized medicine would have to put forth concerning expanded social legislation.

The secretary read a letter from the Board of Trustees of the Indiana State Dental Association. The secretary was instructed to write a letter of appreciation to the Board for their position regarding the Kerr-Mills bill.

The Committee reviewed the recent publication of the *Criterion* in which the interview given by Dr. Owsley was published and the secretary read a letter of commendation concerning this from the American Medical Association.

Organization Matters

The secretary read a letter from the attorneys addressed to the New York Central Mutual Association for the information of the Committee.

Request of the National Foundation for the Association to appoint representatives to a Scholarship Committee was turned down upon motion of Drs. Glock and Wilkens.

A letter from the president of the Woman's Auxiliary concerning participation of the Auxiliary as such in fund-raising drives was read in which the president said that the only two drives in which the Auxiliary was asked to participate as an Auxiliary were the AMEF and funds for scholarships in the field of health careers.

The request of the Northern Tri-State Postgraduate Medical Association for use of the Association mailing list was approved on motion of Drs. Glock and Stimson.

The report of the Commission on Inter-Professional Relations and a question referred to this Commission concerning an amendment to the rules and regulations of the Joint Committee on the Improvement of Patient Care were approved on motion of Drs. Glock and Wilkens.

The recommendation of the Commission on Public Health that the Indiana State Medical Association join the Indiana Foundation for Traffic Safety and contribute \$100.00 was turned down upon motion of Dr. Wilkens and taken by consent.

A letter from the Better Business Bureau concerning the efforts of the security companies to sell worthless oil stocks to physicians and dentists was read. The secretary was instructed to carry this item in the News Flash.

Annual Convention, Indianapolis, October 24, 25 and 26, 1961

Tentative outline for 1961 of the scientific program was reviewed and by consent the stag party and buffet smoker listed on Monday night is to be stricken from the program.

The secretary informed the Committee of turning over for collection to the attorney the account of one exhibitor for the 1960 meeting.



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hand in
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"superior to aspirin"² and with a "higher 'therapeutic index'"¹

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When conservative steroid therapy is indicated—

PABALATE®-HC

Pabalate with Hydrocortisone

In each yellow enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.)
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Sodium para-aminobenzoate
(5 gr.) 0.3 Gm.
Ascorbic acid 50.0 mg.

In each pink enteric-coated PABALATE-SODIUM FREE tablet:

Same formula as PABALATE, with sodium salts replaced by potassium salts.

In each light blue enteric-coated PABALATE-HC tablet:

Same formula as PABALATE-SODIUM FREE, plus hydrocortisone (alcohol) . . . 2.5 mg.

1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

Making today's medicines with integrity . . . seeking tomorrow's with persistence.

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New Business

The president discussed the offer of the Muncie Travel Service and the Scandinavian Air Lines who desire to promote a European tour following the New York AMA meeting, with the Association promoting the information on the tour. Participation by the Association was approved by consent.

Future Meetings

AMA Council on Medical Education and Hospitals meeting, Feb. 4, 1961, Chicago. A letter from Dr. Leland S. McKittrick requesting that some of the officers of the Association meet with the Council on Medical Education during the forthcoming meeting at Chicago on Feb. 4 was discussed and no action was taken other than that previously taken in which Dr. Frank Land was authorized to attend.

There being no further business the Committee adjourned to meet again at the Hay-Adams Hotel, Washington, D. C., Feb. 14, 1961.

EXECUTIVE COMMITTEE

February 14, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.; James A. Waggener, executive secretary.

Membership Report

Number of members as of Dec. 31, 1960.....4,308
1961 members as of Jan. 31, 1961:

Full dues paying	1,649
Residents and interns	121
Council remitted	18
Senior	367
Military	30

Total 1961 members as of Jan. 31, 1961.....	2,185
Loss over last year	140
Number of members as of Jan. 31, 1960.....	2,325
Number of AMA members as of Jan. 31, 1960..	2,406
1961 AMA members: Dues paying	1,557
Exempt, but active	553

Total 1961 AMA members as of Jan. 31, 1961..	2,110
Loss over last year	296
Number who have paid state dues but not	
AMA dues in 1961	32

Headquarters Office

A letter from the Hoosier State Press Association offering a full page in their convention issue of their publication for \$60.00 was read and the purchase of the space was approved on motion of Drs. Wilkens and Glock.

For the information of the committee the secretary reported on the dues collection and building fund collection.

Treasurer's Office

Statement of Income and Expenses as of Jan. 31, 1961, was reviewed and approved by consent. The secretary was instructed to attach a statement of Income and Expenses for *The Journal* for future meetings of the Executive Committee.

Statement of the Investment Account was reviewed and approved by consent.

Building Committee

Upon motion of Drs. Owsley and Glock the Building Committee was authorized to purchase from Samuel J. Mantel and heirs the property under option located at 3935 N. Meridian Street. The committee was further empowered to proceed in the taking of bids for the construction of the building.

Upon motion of Drs. Glock and Owsley the secretary was instructed to send to each county society and to each councilor a breakdown of the membership and contributions to the building fund on record as of March 1.

Legislation

Local: Dr. Wood reported on the activities of the Commission on Legislation and specifically discussed the position taken by the Association on the Corporate Practice Bill, pointing out the action of several groups in the state who were supporting this bill against the opposition of the Association. By consent it was agreed the Association would still oppose the passage of this legislation.

Dr. Wood also discussed the breakfast to be held with the Congressmen on Feb. 15 and reviewed for the Committee the material which the Commission on Legislation was distributing to the councilors and all component county societies covering legislative activities.

National: President Kennedy's Social Security expansion program was discussed as were the plans for the organization of a National Physicians' Political Committee.

Read for the information of the Committee was a letter from the American Medical Association requesting that names be submitted to it for legislative key contact personnel within the state. This was left to the chairman of the committee and the executive secretary.

Annual Convention, Indianapolis, Oct. 24, 25 and 26, 1961

Report on sale of exhibit space for the 1961 annual convention was noted.

Organization Matters

A letter addressed to President Guy A. Owsley from Councilor John Paris was read for the information of the Committee.

Letter from Dr. Harold King requesting use of the State Association mailing list for calling attention to the meeting of the Indiana Chapter of the American College of Surgeons, to be held in Indianapolis April 14 and 15, 1961, was approved by consent.



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Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed — *often in a few days*. She eats well, sleeps well and soon returns to her normal activities.

Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood — no “seesaw” effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient — *they often aggravate anxiety and tension*.

And although amphetamine-barbiturate combinations may counteract excessive stimulation — *they often deepen depression*.

In contrast to such “seesaw” effects, Deprol’s smooth, *balanced* action lifts depression as it calms anxiety — both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days.

Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage.

Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function — frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzi-late hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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Letter from the American Medical Association to the Marion County Medical Society was read.

Letter from Dr. A. C. Offutt was read, informing the Association that the Board of Health had received word there were some 300 Cuban physicians exiled in Florida looking for employment. By consent it was agreed that the secretary should thank Dr. Offutt for this information. No further action was taken.

Letter received from Merck, Sharpe & Dohme concerning an offer they had made to the State Department of Public Welfare for a 10% discount on their products prescribed for welfare recipients was read for the information of the Committee.

A letter from the Michigan State Medical Society asking the opinion of the Indiana State Medical Association on a joint meeting of several of the states to try and encourage a uniform procedure on transfer of membership was read and by consent the secretary was instructed to notify the Michigan State Medical Society that Indiana would be willing to consider such an effort.

Letter from the Commission on Constitution and By-laws was read, no action being taken as this will be reported to the House of Delegates.

Letter from Ethel R. Jacobs, R.N., director of the Division of Public Health Nursing of the Indiana State Board of Health, concerning representation of the Association on the Advisory Committee on Nurse Aide Training was read and reply is to be left with the president, Dr. Owsley.

Letter from Dr. C. Philip Fox, secretary of the Daviess-Martin County Medical Society, was read for the information of the Committee.

CBS telecast on "The Business of Health" was reviewed and letters from the AMA, as well as letters from Drs. H. R. Stimson, E. T. Edwards, John Paris, E. S. Rifner and Robert M. Brown, addressed to CBS, were read for the information of the Committee.

A suggested survey on hospital admissions of persons over 65 with a breakdown as to those who were able to pay their hospital bills from their own assets, insurance, etc., or whether they required assistance in the payment of their bills, was discussed, and this matter is to be referred to the Council at its next meeting.

New Business

Notification from the Office for Dependents' Medical Care concerning the advance payment bank account for the operation of the Medicare program was read and by consent the secretary was instructed to complete these arrangements.

A letter from the Wabash County Medical Society was read and by consent this was ordered referred to the Blue Shield Liaison Committee.

Payment of dues to the Joint Committee on Improvement of Patient Care in the amount of \$25.00 was approved on motion of Drs. Glock and Owsley.

The Journal

A letter from the State Journal Advertising Bureau concerning charges for handling advertising was read and approved by consent.

Future Meetings

AMA annual session, New York, June 13 to 17, 1961.

The secretary brought up the fact that since the Executive Committee had approved a European tour proposed by the Muncie Travel Service that Trans World Airlines and Gausepohl Travel Service had also brought in proposed tours and he asked which of the tours should be promoted by the Association. By consent, he was instructed to give the members their choice.

There being no further business the Committee adjourned to meet again at 5:00 p.m. on March 22, 1961, at the Student Union Building in Indianapolis. (Later the meeting date was changed to March 29, 1961.)

EXECUTIVE COMMITTEE

March 29, 1961.

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.; Frank B. Ramsey, M.D.; Robert Hollowell, attorney; James A. Waggener, executive secretary.

Minutes of the meeting held Feb. 14, 1961, were approved on motion of Drs. Stimson and Covalt.

Membership Report

Number of members as of Dec. 31, 1960-----4,309
1961 members as of Feb. 28, 1961:

Full dues paying-----	3,154
Residents and interns-----	159
Council remitted-----	24
Senior -----	372
Honorary -----	1
Military -----	33

Total 1961 members as of Feb. 28, 1961-----3,743

Loss over last year-----94

Number of members as of Feb. 28, 1960-----3,837

Number of AMA members as of Feb. 28, 1960--3,740

1961 AMA members: Dues paying-----3,048

Exempt but active--602

Total 1961 AMA members as of Feb. 28, 1961 3,650

Loss over last year-----90

Number who have paid state dues but not AMA

dues in 1961-----106

Headquarters Office

Renewal of Blue Cross-Blue Shield contract was approved on motion of Doctor Covalt and taken by consent.

Building Matters

The contract for the wrecking of the building at 3935 North Meridian, as signed by the building committee and the attorney, was confirmed by consent.

The secretary reported on the number of members by county and the number who have contributed to the building fund.

It was decided on motion of Dr. Owsley and seconded by Dr. Stimson that groundbreaking ceremony for construction of the new headquarters building would be held at the close of the Council meeting April 9. In the same motion, the secretary was instructed to

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The combined spectrum of three overlapping antibiotics will eradicate virtually all known topical bacteria.

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Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)



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write a letter of special invitation to the president of the Indianapolis Medical Society, chairman of the Board of Trustees of Indianapolis Medical Society and to the president of the Woman's Auxiliary of the Indiana State Medical Association to be guests of the Association at the groundbreaking ceremony.

A statement covering legal services for the litigation and rezoning of the property at 3935 North Meridian St., was ordered paid from the building fund upon motion of Drs. Wilkins and Covalt.

Treasurer's Report

The C.P.A.'s first quarter audit statement of income, expenses and budget balances for the headquarters office and *Journal* was reviewed by the treasurer and the report was approved by consent.

Legislation

National: Dr. Wood discussed national legislation and the plans for the appearance of Doctor Annis in Indianapolis April 25.

Dr. Wood announced plans for the trip to Washington April 30.

Local: Local legislation was discussed by Dr. Wood. No questions were asked concerning the report previously distributed, outlining the results of the state legislative program.

Attorneys discussed the meaning and effect of Senate Bill 436. This matter will be discussed further by the Council at its meeting April 9.

Annual Convention, Indianapolis, Oct. 24, 25 and 26, 1961

Sale of exhibit space for the convention was noted.

Organization Matters

The secretary reported that 235 were in attendance for the annual Junior-Senior Day, and a letter was read from one of the students, commenting on the excellence of the program. Dr. Owsley commented on the talk made by Mr. Wenger.

Renewal of the Medicare contract and for the advance payment effective April 1, 1961, was approved for the president's signature on motion of Drs. Covalt and Wilkens.

Dr. Owsley commented on the formation in Indiana of a student loan plan known as HELP, standing for higher education loan plan. By consent, it was agreed that Mr. E. B. Newill and Mr. Funk, of Indiana National Bank, be invited to discuss this program before the Council at its meeting April 9.

A letter from AMA calling attention to area meetings being conducted by COPE was read for information of the committee.

A request for a \$35 contribution to the Press Club was approved on motion of Doctors Covalt and Wilkens.

A written report from Dr. Francis L. Land, who represented the Association at the annual meeting of the Council on Medical Education and Hospitals, was favorably received on motion of Drs. Wilkens and Covalt.

A preliminary report of the Ad Hoc Osteopathic Liaison Committee was reviewed for the information of the committee.

A resolution forwarded by the North Carolina State Medical Association was read, as was a resolution forwarded by the Kansas State Medical Society. On motion of Doctors Stimson and Covalt, these two resolutions are to be referred to the Council.

Future Meetings

Future meetings are noted:

State Chamber of Commerce, French Lick, April 7, 8 and 9

5th Annual State Convention, Medical Assistants, April 22-23, South Bend

Doctor Annis, Indianapolis, April 25.

Auxiliary convention, South Bend, April 27-28, 1961.

ISMA Congressional dinner, Washington, May 1.
Indiana State Chamber of Commerce Congressional dinner, May 2.

U. S. Chamber of Commerce, Washington, April 30-May 3.

AMA, New York, June 25-29, 1961.

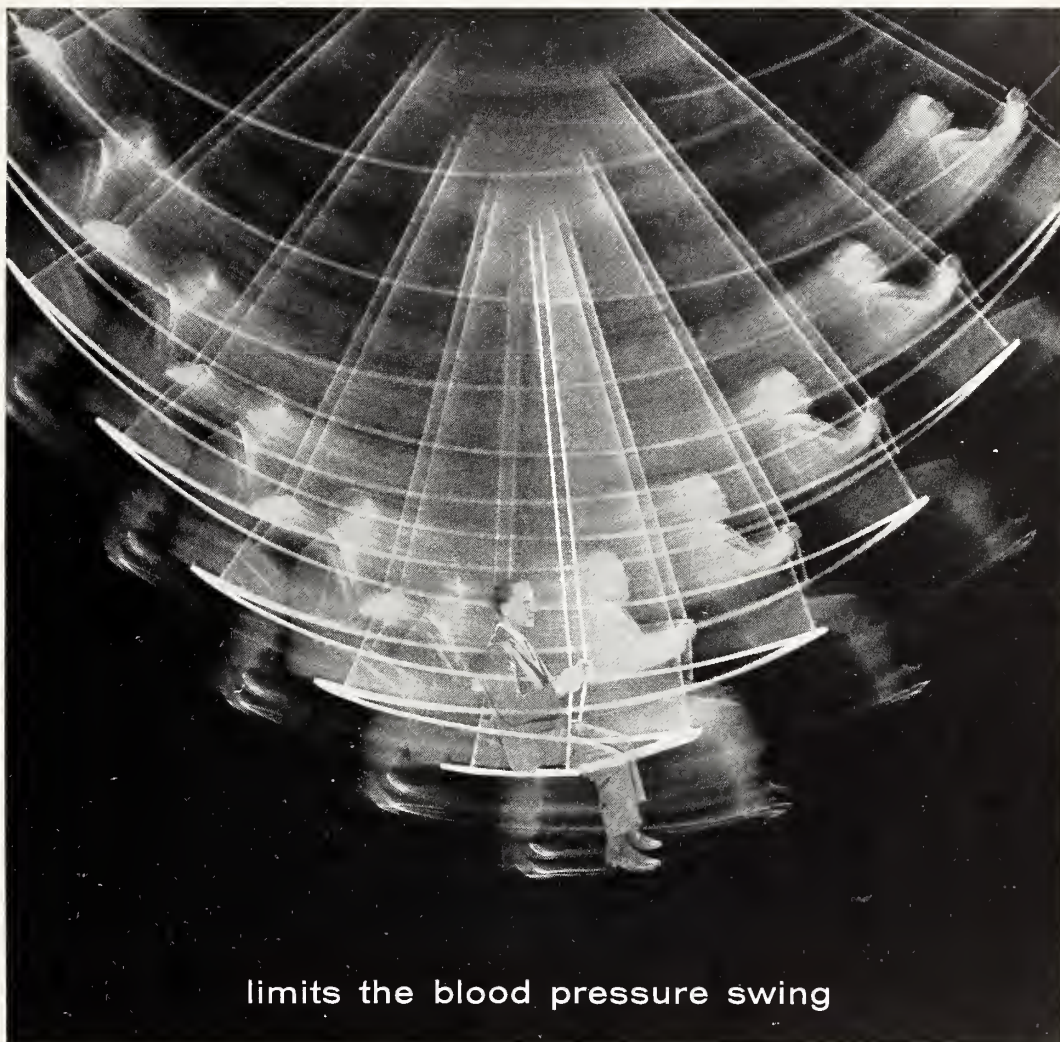
Training Institute, Medical Care for the Needy, Ann Arbor, Michigan, July 10-21, 1961.

10th Annual U. S. Civil Defense Council, Los Angeles, October 16-20, 1961.

Dr. Wood will attend the meeting of the State Chamber of Commerce at French Lick, and it was decided that no representative would be sent to the Training Institute, Medical Care for the Needy, or to the 10th Annual U. S. Civil Defense Council meeting.

It was agreed that the delegation while in Washington should attend the luncheon Tuesday, May 2, dealing with health care for the aged.

There being no further business, the Committee adjourned to meet again at 6:00 p.m. Saturday, April 8, 1961, at which time the building committee is to be asked to meet with them. ◀



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Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.



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THE COUNCIL

January 15, 1961.

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:00 a.m. (EST), Sunday, January 15, 1961, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Maurice E. Glock, chairman, presiding. Roll call showed the following present:

Councilors:

First District—William B. Challman, Mount Vernon.

Second District—E. T. Edwards, Vincennes.

Third District—John M. Paris, New Albany (also AMA alternate delegate). Donald M. Kerr, Bedford, alternate.

Fourth District—Joe M. Black, Seymour.

Fifth District—V. Earle Wiseman, Greencastle; A. W. Cavins, Terre Haute, alternate (also associate editor, *The Journal*).

Sixth District—Harry P. Ross, Richmond; William R. Tindall, Shelbyville.

Seventh District—Ralph V. Everly, Indianapolis.

Eighth District—Gordon B. Wilder, Anderson (also AMA delegate).

Ninth District—Kenneth O. Neumann, Lafayette; Albert E. Stouder, Kempton, alternate.

Tenth District—James P. Vye, Gary; Ralph C. Eades, Valparaiso, alternate.

Eleventh District—E. S. Rifner, Van Buren.

Twelfth District—Maurice E. Glock, Fort Wayne.

Thirteenth District—Burton E. Kintner, Elkhart.

Officers:

Guy A. Owsley, Hartford City, president.

Harry R. Stimson, Gary, president-elect.

Irvin W. Wilkens, Indianapolis, treasurer.

Charles F. Gillespie, Indianapolis, assistant treasurer.

Journal:

Frank B. Ramsey, Indianapolis, editor.

Executive Committee:

Wendell E. Covalt, Muncie, member.

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate.

Francis L. Land, Fort Wayne, AMA delegate and chairman, Commission on Medical Education and Licensure.

Robert M. Brown, Marion, AMA alternate delegate.

James M. Leffel, Indianapolis, chairman, Commission on Convention Arrangements.

Earl W. Mericle, Indianapolis, president 1960.

Philip B. Reed, Indianapolis, chairman, Grievance Committee.

John D. Van Nuys, Indianapolis, dean, I. U. School of Medicine.

A. C. Offutt, Indianapolis, State Health Commissioner.

Stewart T. Ginsberg, Indianapolis, Liaison Committee on Mental Health.

Norman R. Booher, Indianapolis, chairman, Commission on Voluntary Health Agencies.

Frank H. Green, Rushville, member, Commission on Inter-Professional Relations.

Officers of Marion County Medical Society:

M. H. Nourse, president.

C. Powell VanMeter, president-elect.

Floyd A. Boyer, past president.

A. M. Donato, chairman of the Council.

Staff:

Robert Hollowell, Indianapolis, attorney.

Ralph Hamill, Indianapolis, attorney.

Robert J. Amick, field secretary.

Howard Grindstaff, field secretary.

J. A. Waggener, executive secretary.

On motion of Drs. Everly and Neumann, minutes of the Council meetings held at French Lick on Oct. 2 and 5, 1960, were approved as printed in the December, 1960 issue of *The Journal*.

On motion of Drs. Everly and Challman, the minutes of the special meeting of the Council, held December 26, 1960, which were contained in a letter sent to each councilor, were approved.

Reports of Councilors

The councilors announced, or confirmed, the following district meeting dates for 1961:

First District—Evansville, May 18, 1961.

Second District—Washington, June 8, 1961.

Third District—Jasper, May 11, 1961.

Fourth District—Seymour, May 17, 1961.

Fifth District—Turkey Run, May 17, 1961.

Sixth District—Rushville, May 11, 1961.

Seventh District—Indianapolis, May 17, 1961.

Eighth District—Muncie, June 7, 1961.

Ninth District—Crawfordsville, May 18, 1961.

Tenth District—Whiting, May 10, 1961.

Eleventh District—Huntington, May 17, 1961.

Twelfth District—Columbia City, May 17, 1961.

Thirteenth District—LaPorte, Sept. 27, 1961.

Collection of the \$50.00 building fund contribution in the various districts was discussed and the progress to date reported.

The chairman called attention to two items concerning district meetings: (1) The Bylaws require dates of district meetings to be in the headquarters office by January 1, or the councilor is responsible for establishing the date at the January meeting of the Council, and (2) programs for district meetings should be in the headquarters office 45 days in advance of district meetings to allow time for distribution to all district members 30 days prior to district meetings.

By consent the Council instructed the executive secretary to send Dr. E. S. Jones the best wishes of the Council and to express the hope of the Council for his speedy recovery.

Reports of Officers

DR. GUY A. OWSLEY, president, reported to the Council in executive session.

DR. IRVIN W. WILKENS, treasurer, reported on the financial status of the Association, saying that it is still in the black, and presented the annual audit of Wolf and Company, certified public accountants, for the period from Oct. 1, 1959, to Sept. 30, 1960, which follows:

FINANCIAL REPORT

WOLF AND COMPANY

Certified Public Accountants

The Council

Indiana State Medical Association

Indianapolis, Indiana

We have examined the financial records of Indiana State Medical Association for the year ended September 30, 1960. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying financial statements present fairly the position of Indiana State Medical Association at September 30, 1960, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
Wolf and Company
Certified Public Accountants

Indianapolis, Indiana

November 1, 1960

INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana

Exhibit A

STATEMENT OF FUNDS

September 30, 1960

ASSETS

General fund:			
Cash	52,526.04		
Note receivable	1,472.61		
Inventory—tape recorder	271.64		
Deposits with postmaster	635.62		
Prepaid expenses	2,475.88		
Accrued interest receivable	2,768.99		
Due from medical defense fund	1,778.31		
Due from student loan fund	5,101.29	6,879.60	
Reimbursement due for Medicare expenses ...	2,750.35		
Investments, at cost, less amortization (Note):			
U. S. Treasury bonds,	145,544.39		
U. S. Treasury bills,	43,369.40		
U. S. Treasury notes,	15,000.00		
U. S. Savings bonds,	76,000.00		
	279,913.79		
Less accumulated amortization	341.28	279,572.51	
Office furniture and equipment			
General office	17,285.27		
Medicare office	4,437.52		
	21,722.79		
Less accumulated depreciation	7,185.75	14,537.04	363,890.28

The Journal:

Cash	236.03		
Accounts receivable			
Advertising	10,441.78		
Other	221.80	10,663.58	
Due from general fund		14,439.35	
Postal deposits		203.09	25,542.05
Medical defense fund:			
Cash	3,312.08		
Accrued interest receivable	118.60		
Investments, at cost, less amortization:			
U. S. Treasury bonds,	14,235.94		
U. S. Treasury bills,	2,981.10		
U. S. Savings bonds,	9,000.00		
	26,217.04		
Less accumulated amortization	184.69	26,032.35	29,463.03
Student loan fund:			
Cash	2,065.23		
Notes receivable	18,524.95	20,590.18	
			439,485.54

Note:

Investments in U. S. Treasury securities aggregating \$150,000.00 have been allocated to the building fund.

LIABILITIES

General fund:

Liabilities:

Accounts payable	2,798.54		
Accrued payroll taxes	111.09		
Due American Medical Education Fund	36,225.00		
Due The Journal	14,439.35		
Pledged to building fund.....	18,075.00		
Unrealized convention income ..	11,872.50		
Dues collected in advance	27,928.00		
Deposits on tape recordings....	270.50		
Amount due officer	58.79		
	111,778.77		
Fund surplus (Exhibit B).....	252,111.51		
			363,890.28
The Journal:			
Liabilities:			
Accounts payable	304.31		
Prepaid professional cards.....	2,228.28		
	2,532.59		
Fund surplus (Exhibit B).....	23,009.46		
			25,542.05

Medical defense fund:

Due to the general fund	1,778.31		
Fund surplus (Exhibit B)	27,684.72		
			29,463.03

Student loan fund:

Due to the general fund.....	5,101.29		
Fund surplus (Exhibit B).....	15,488.89	20,590.18	
			439,485.54

STATEMENT OF FUND SURPLUS

For the Year Ended September 30, 1960

General fund:	
Balance, September 30, 1959.....	236,675.09
Excess of revenues over expenditures (Exhibit C)	15,436.42
Balance, September 30, 1960.....	252,111.51
The Journal:	
Balance, September 30, 1959.....	32,462.92
Excess of expenditures over revenues (Exhibit D)	9,453.46
Balance, September 30, 1960.....	23,009.46
Medical defense fund:	
Balance, September 30, 1959.....	29,464.42
Excess of expenditures over revenues (Exhibit E)	1,779.70
Balance, September 30, 1960.....	27,684.72
Student loan fund:	
Balance, September 30, 1959.....	15,333.17
Interest earned	145.72
Gift received	10.00
Balance, September 30, 1960.....	15,488.89

STATEMENT OF REVENUES AND EXPENDITURES

For the Year Ended September 30, 1960

GENERAL FUND		Actual Over (Under*) Budget
Actual	Budget	
Revenues:		
Dues	186,991.25	179,320.00
Less dues allocated:		
The Journal	12,231.00	11,268.00
Medical defense fund..	4,801.25	4,695.00
American Medical Education fund	36,225.00	35,440.00
Building fund	18,075.00	17,720.00
	71,332.25	69,123.00
Dues available for operations	115,659.00	110,197.00
Interest on investments..	9,876.71	8,500.00
Received from AMA	1,158.93	730.00
Net income—annual meeting	5,315.55	5,315.55
Other income	565.08	565.08
Total revenues	132,575.27	119,427.00
Expenditures:		
Committees and commissions (Schedule C-1) ..	18,734.55	26,150.00
Officers and council (Schedule C-2)	11,398.41	12,775.00
Headquarters office (Schedule C-3)	79,532.74	79,375.00
Woman's Auxiliary	1,596.67	1,000.00
Employes' retirement fund	5,876.48	5,000.00
Total expenditures ..	117,138.85	124,300.00
Excess of revenues over expenditures (expenditures over revenues*)	15,436.42	4,873.00*

STATEMENT OF OPERATING EXPENDITURES

For the Year Ended September 30, 1960

COMMITTEES AND COMMISSIONS		Actual Over (Under*) Budget
Actual	Budget	
Standing committees:		
Grievance	473.86	450.00
Student loan	22.55	100.00
Medical legal review ...	50.00	50.00*
Commissions:		
Constitution and by-laws	452.30	500.00
Interprofessional relations	450.00	450.00*
Legislation	5,521.20	6,000.00
Public health	739.19	2,500.00
Public information ...	6,577.46	7,000.00
Special activities	178.13	200.00
Voluntary health agencies	800.97	900.00
Medical economics and insurance	1,394.74	2,000.00
Medical education and licensure	1,130.07	3,000.00
Building	522.47	2,000.00
Government medical services	921.61	1,000.00
Totals	18,734.55	26,150.00

OFFICERS AND COUNCIL

Actual Over (Under*) Budget	Actual	Budget
President	631.41	1,500.00
President elect	878.72	500.00
Council chairman	29.60	300.00
AMA delegates	3,711.51	4,000.00
AMA meetings	1,866.75	2,000.00
Treasurer, auditing and bookkeeping	1,550.00	1,125.00
Council travel	903.90	800.00
Council meetings	874.97	1,200.00
Better Business Bureau...	150.00	150.00
Executive committee:		
Travel	522.26	600.00
Meetings	279.29	600.00
Totals	11,398.41	12,775.00

HEADQUARTERS OFFICE

Actual Over (Under*) Budget	Actual	Budget
Salaries	47,383.11	50,000.00
Supplies	2,354.07	1,600.00
Telephone and telegraph..	2,944.47	3,000.00
Postage	2,374.91	1,600.00
Printing and stationery...	1,179.52	1,700.00
Travel	10,183.79	9,000.00
Rent and electricity.....	4,308.05	4,400.00
Organization memberships.	1,376.75	400.00
Donations	685.00	100.00
Insurance:		
Hospitalization	835.78	800.00
Other	1,740.95	550.00
Photographic equipment expenses	25.56	25.00
Extra help	619.12	800.00
Payroll taxes	1,027.13	1,100.00
Depreciation	1,825.23	1,200.00

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Maintenance—office			
machines	363.87	363.87
Unallocated	305.43	3,100.00	2,794.57*
Totals	79,532.74	79,375.00	157.74

STATEMENT OF REVENUES AND EXPENDITURES

For the Year Ended September 30, 1960

Exhibit D

THE JOURNAL

	Actual	Budget	Actual Over (Under*) Budget
Revenues:			
Subscriptions:			
Members	12,231.00	11,268.00	963.00
Nonmembers	451.50	332.00	119.50
Advertising	71,458.23	74,000.00	2,541.77*
Other	1,109.86	1,000.00	290.14*
Total revenues	85,250.59	87,000.00	1,749.41*
Expenditures:			
Salaries (including extra help)	13,582.87	13,720.00	137.13*
Office expense	1,016.74	710.00	306.74
Printing and reprints ..	66,495.71	57,100.00	9,395.71
Engravings	6,334.73	5,120.00	1,214.73
Travel and meetings ...	1,723.16	2,150.00	426.84*
Bulk mailing	1,017.73	1,350.00	332.27*
Other publishing expense	1,139.60	1,790.00	650.40*
Payroll taxes	355.81	340.00	15.81
Employe group insurance	123.00	60.00	63.00
Rent and electricity ...	2,175.98	2,150.00	25.98
Telephone and telegraph	195.49	270.00	74.51*
Dues and memberships..	81.50	.....	81.50
Prizes	225.00	.....	225.00
Unallocated	236.73	240.00	3.27*
Total expenditures ..	94,704.05	85,000.00	9,704.05
Excess of revenues over expenditures (expenditures over revenues*)	9,453.46*	2,000.00	11,453.46*

Exhibit E

MEDICAL DEFENSE FUND

Revenues:		
Transfer of applicable portion of dues	4,801.25	
Interest earned—U. S. Treasury bonds	809.53	
Amortization of discounts—U. S. Treasury bonds	4.80	
Total revenues		5,615.58
Expenditures:		
Malpractice fees	4,636.67	
Legal fees	2,640.00	
Stationery and printing.....	118.61	
Total expenditures		7,395.28
Excess of expenditures over revenues		1,779.70

Exhibit F

STUDENT LOAN FUND

Cash balance, September 30, 1959....		1,470.06
Revenues:		
Collection of student loans.....	2,982.79	
Interest earned	145.72	
Gift	10.00	3,138.51
Expenditures—loans to students.....		4,608.57
Cash balance, September 30, 1960....		2,543.34
		2,065.23

Delegates to the AMA. Dr. Harold C. Ochsner, AMA delegate, and Dr. Robert M. Brown, AMA alternate delegate, reported on the actions taken by the AMA House of Delegates at the clinical meeting held in Washington, Nov. 28 to Dec. 1, 1960. (See January 1961 *Journal* for full report.)

Unfinished Business

1. *Participation in National Science Fair.* Dr. Wendell Covalt reported that the Executive Committee, at its Nov. 1, 1960, meeting voted that the Indiana State Medical Association would not participate in the 1961 National Science Fair.

At its December meeting the Committee received from the Commission on Medical Education and Licensure the recommendation for continued participation in the Science Fair and the request that the Executive Committee reconsider its previous action and appropriate an amount not to exceed \$3,000.00, this amount to be used for defraying transportation costs of those winners whose exhibits are in the field of the biological sciences. The Executive Committee, after due consideration of the recommendation of the Commission, reaffirmed its vote not to participate, and moved that the matter be referred to the Council.

This subject was discussed before the Council by Drs. Mericle, Eades, Owsley, Challman, Paris, Neumann and Black.

On motion of Dr. Paris, duly seconded, the Council voted to contribute up to \$2,000.00 to defray the traveling expenses of only the winners in the biological sciences from each of the eleven regional fairs.

2. *Resolution No. 1, Recommendation in Regard to Specialization.* The following resolution, introduced by the Lawrence County Medical Society at the 1960 meeting of the House of Delegates, was referred by the Reference Committee on Medical Education and Hospitals to the Commission on Medical Education and Licensure "for further consideration and study before any hasty decision is made."

WHEREAS The number of Family Doctors is being depleted by specialization, and

WHEREAS The Family Doctor is being replaced by Chiropractors, Osteopaths and Cultists, and

WHEREAS The deficiency cannot be met by more graduates from approved medical schools, inasmuch as students proceed directly into specialization, and

WHEREAS Only by having good medical Doctors to refer them patients can a Specialist obtain an ethical practice, and



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CREMOSUXIDINE® [SULFASUXIDINE® SUCCINYL SULFATHIAZOLE SUSPENSION WITH KAOLIN AND PECTIN] reduces fluidity of stools, reduces enteric bacteria, adsorbs toxins, and soothes the irritated intestinal mucosa.

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WHEREAS A Specialist should understand the relationship of the patient in the Family Doctor situation;

THEREFORE BE IT RESOLVED that the Indiana State Medical Association recommend to all Specialty Boards and to the American Medical Association that all applicants have at least two years' general practice as a requirement for specialization.

Dr. Francis L. Land, chairman of the Commission on Medical Education and Licensure, reported that "the Commission is of the opinion that although a problem exists in securing an adequate number of family physicians, Resolution No. 1 is not practical and will not alleviate this problem. Therefore the Commission recommends to the Council that this resolution be tabled."

On motion of Drs. Black and Edwards the Council accepted the report of the Commission on Medical Education and Licensure.

3. *Building Committee.* Dr. Everly, chairman, reported that "at the present time the Building Committee stands by, ready to proceed whenever we find out two things: Do we have a site, and how much money do we have?"

Judge Ralph Hamill, attorney, reported on the progress of the suit for rezoning of the site.

The executive secretary reported on the number of members who had contributed to the Building Fund.

The officers of the Marion County Medical Society, Drs. M. H. Nourse, president, C. Powell VanMeter, president-elect, Floyd A. Boyer, past president, and A. M. Donato, chairman, Board of Directors, appeared before the Council.

4. *Student Loan Fund.* Dr. Ross, chairman of the Committee on Student Loan, discussed the matter of interest rates on loans to students since the establishment of the Student Loan Fund, and the action taken by the Committee at its Oct. 30, 1960, meeting, as follows:

"On motion of Dr. Bibler, seconded by several, the Committee voted to recommend to the Council that the interest rate of 2 percent on loans be made retroactive to apply to all loans granted prior to the Oct. 5, 1960, action of the House of Delegates."

For the information of the Council the chairman read from the minutes of the October 1960 meetings of the House of Delegates as follows:

"Your Committee (Reference Committee on Medical Education and Hospitals), after a full study of the report of this committee (Student Loan), makes the following recommendation:

"That the previous action of the House of Delegates to establish an interest rate of 6% on loans to students to be rescinded and that a new nominal interest rate of 2%, to cover expenses only, be authorized by this body to become effective immediately with the granting of future loans."

On motion of Drs. Black and Rifner the Council went to record as disapproving the recommendation of the Student Loan Committee which would make the interest rate of 2 percent retroactive to apply to all loans granted prior to Oct. 5, 1960.

5. *Activities of the Liaison Committee between the Council and Blue Shield* were discussed by Dr. Challman, chairman, and Drs. Paris and Edwards, members of the Liaison Committee. Several points were stressed:

(1) This liaison committee must be kept in action. "If we can continue with the interest between the Council and the Blue Shield Board, I think we can solve our problems," Dr. Paris said. (2) Dr. Edwards: "It behooves all physicians in Indiana to remember that insurance follows the risk; in other words, from our viewpoint, medical and surgical benefits must follow fees, not precede them. We can't delegate our responsibilities for establishing our fees to an insurance company and then bring our charges up to what the insurance company is giving. Second, Mr. Saylor made a point at the end of that last Board meeting, it being that he wished the Medical Association would do something about the problem of over-abuse or over-utilization of insurance. He suggested either utilization committees or admissions committees, and this applies largely to us in non-surgical practice; in other words, the medical diagnostic cases. . . . The large bulk buyers, the steel unions and others, are emphasizing all the time that we should leave fee for service and go to panel salaried practice because of savings for insurance companies. It is a problem that the physicians in Indiana are going to have to face more seriously than they have in the past."

Discussed also by Dr. Owsley, who asked if the Council would be interested in reviewing the cases that had been flagged for overcharges. "The Blue Shield Executive Committee has kept a pattern of some of the, what they consider, abuses, and the committee wanted to know if I would bring this to the Council for consideration of passing these cases on to the State Medical Grievance Committee. Rather than do that, I thought it might be better for the Commission on Insurance and Medical Economics to listen to some of these cases; then if they felt they were justified, bring them to the Council and you can decide whether or not you want to add that additional work on Phil Reed."

This subject was further discussed by Drs. Paris, Ross and Black. No action was taken.

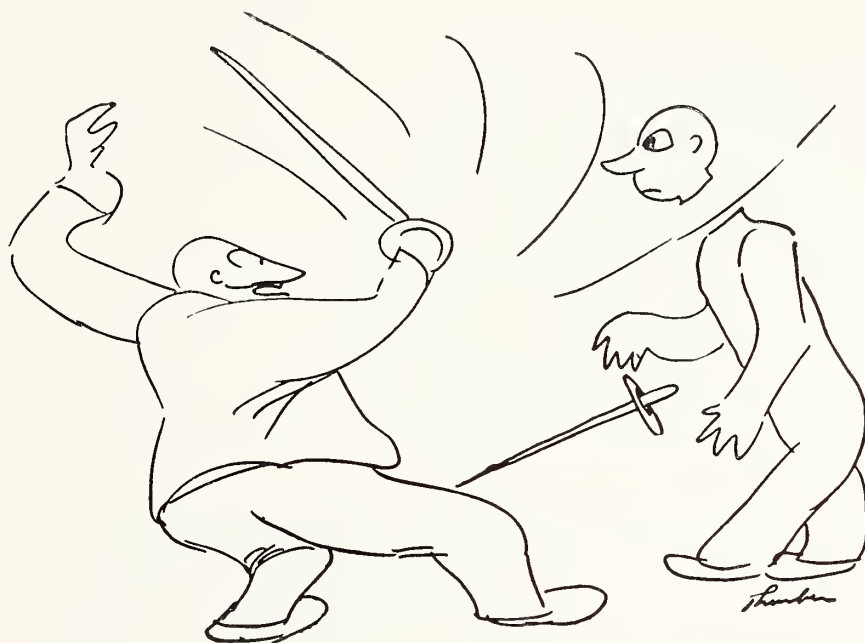
6. *Blue Shield Board members.* Members-at-large for the three-year term ending March 1, 1964, were nominated as follows:

John W. Beeler, Indianapolis (radiology), to succeed himself. (Nominated at Oct. 2, 1960, Council meeting.)

William E. Bayley, Lafayette (pathology), on motion of Drs. Neumann and Everly, to succeed Marlow W. Manion, Indianapolis (E. N. T.)

Dr. Everly withdrew the nomination of Dr. Thomas W. Johnson, Indianapolis, which was made at the Oct. 2, 1960, Council meeting.

7. *Osteopathic matters.* Dr. Owsley, at the request of Dr. Challman, chairman of the Council Fact-finding Committee on Osteopathy, reported on his meeting in Washington with the AMA Judicial Council. He said he had appointed a liaison committee, as requested by the Judicial Council, which should work closely with the present committee which has been studying the local issues. "We think the thing will be resolved in New York in June."



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8. *Letter from Dr. M. A. Austin*, past president of the Association, was read by the chairman.

1961 Annual Convention, Indianapolis

Dr. James M. Leffel, chairman of the Commission on Convention Arrangements, outlined the scientific and entertainment program as follows:

Monday, October 23, 1961

- 8:30 a.m. Annual golf tournament
- 11:00 a.m. Annual trap-skeet shoot
- Noon Executive Committee meeting
- 3:00 p.m. Council meeting
- Bowling tournament
- 6:00 p.m. Meeting of House of Delegates

Tuesday, October 24, 1961

- 7:30 a.m. Breakfast meeting of Council
- 8:00 a.m. Reference Committee meetings
- 10 to 12 noon Panel on "*Hypertension*"
- Noon Luncheon meeting of past presidents of ISMA
- 2 to 4 p.m. Continuation of panel on "*Hypertension*"
- 6:00 p.m. Reception and annual dinner meeting for women physicians

Wednesday, October 25, 1961

- 7:30 a.m. Breakfast meeting of Council
- 9 to 11 a.m. Instructional courses
- 11:00 a.m. F. J. L. Blasingame, M.D., Chicago, Executive Vice President, American Medical Association, speaking
- 2 to 4 p.m. Panel on "*Surgical Diseases of the Gastro-intestinal Tract.*"
- 5:15 p.m. Reception for members of Fifty-Year Club
- 7:00 p.m. President's reception.
- 8:00 p.m. Annual dinner and dance

Thursday, October 26, 1961

- 7:30 a.m. Breakfast meeting of Council
- 9 to 11 a.m. Section meetings
- 11:00 a.m. Organization meetings of 1961-62 commission and committee members of ISMA
- 1:30 p.m. Final meeting of House of Delegates
- Meetings of Council and Executive Committee immediately following adjournment of House of Delegates

Dr. Edward B. Smith, Indianapolis, will be in charge of the Scientific Exhibits, and Dr. Donald G. Mason, Angola, is chairman of Instructional Courses.

The specialty groups have promised to meet with the Indiana State Medical Association this year. This should increase the annual session attendance and should also bring some outstanding speakers to the meeting.

Legislative Matters

In the absence of Dr. Don E. Wood, chairman of the Commission on Legislation, Dr. Joe Black, member of the Commission, called the attention of the Council to the following matters:

(1) The Commission on Legislation is holding an emergency meeting Wednesday, January 18, in regard to the outcome of the Aged and Aging meeting in Washington, with reference to how Indiana stands.

(2) Legislative problems to be faced in the present session of the Legislature.

The executive secretary called attention to (1) the Corporate Practice Bill, which was explained by Mr. Hollowell, attorney, and (2) the Kerr-Mills Bill, adopted by the last Congress, and about which there is a question of implementation in the State of Indiana.

On motion of Drs. Kintner and Rifner, the Council voted to oppose the Corporate Practice of Medicine legislation.

The secretary read the action taken by the Commission on Governmental Medical Services on the Kerr-Mills bill, which follows, and on which the Council took no action:

The Commission on Governmental Medical Services recommends to the Council of the Indiana State Medical Association that every resource of the ISMA be activated to do everything possible to work for the implementation of the principle of the Kerr-Mills bill in Indiana.

The Commission further recommends that the Council, when and if the Kerr-Mills bill is implemented by the Legislature, that the Council go on record as desiring that the Indiana State Medical Association assume the fiscal administration of the Plan.

Dr. Owsley urged the members of the Council and ISMA to contact their legislators regarding implementation of the Kerr-Mills bill through the existing Old Age Assistance program in Indiana. "We are duty bound as part of the American Medical Association, to try to get this bill implemented because it was the bill of the AMA, and if any of you can talk with your representatives or senators on this particular issue I think it would help the Legislative Commission."

Economic and Organization Matters

1. 1960 membership report by districts, as follows, was presented:

MEMBERSHIP REPORT INDIANA STATE MEDICAL ASSOCIATION DECEMBER 31, 1960

	Members		Gain or Loss over 1959		Removed from ISMA Membership Roles			Non-Members	
	ISMA	AMA	ISMA	AMA	Non- Payment	Trans- fer	Deaths	Eligible	Non- Eligible
1st District									
Gibson	17	17					1		
Perry	12	12	-1	-1				1	

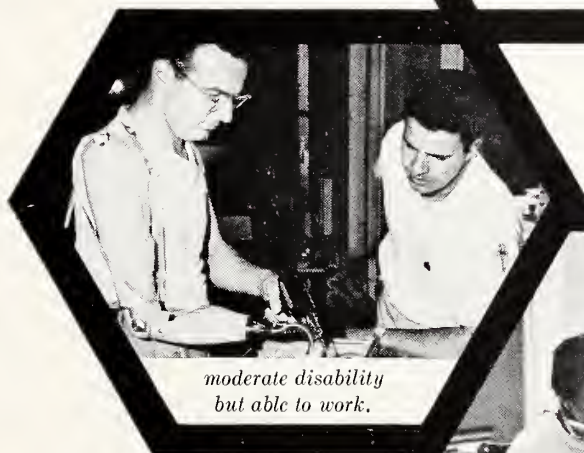
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Chicago
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Possibilities:



return to normal.



*moderate disability
but able to work.*



*severely disabled but not
totally incapacitated.*

*...through comprehensive
rehabilitation for*

- hemiplegia
- paraplegia
- quadriplegia
- amputations
- degenerative diseases of the nervous system
- traumatic disabilities of the hand
- arthropathies

*Services Available
for both in and
out patients:*

- Medical Care
- Nursing Care
- Laboratory Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Service
- Vocational Counseling
- Psychological Service

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*Direct Inquiries to:
Bernard J. Michela, M.D.
Director*

	Members		Gain or Loss over 1959		Removed from ISMA Membership Roles			Non-Members	
	ISMA	AMA	ISMA	AMA	Non- Payment	Trans- fer	Deaths	Eligible	Non- Eligible
Pike	5	5	+1	—					
Posey	11	11	—	—1					
Spencer	6	5	—2	—					
Vanderburgh	214	206	+2	+3			1	7	1
Warrick	12	14	+1	+1				3	
Total	277	270	+1	+2	1		1	11	1

2nd District

Daviess- Martin	22	21	—1	—1			2		
Greene	16	8	—2	—2					
Knox	43	41	+2	+2					
Owen-Monroe	54	52	—	+3	1		1	2	
Sullivan	16	14	+2	+2					
Total	151	136	+1	+4	1		3	2	

3rd District

Clark	33	33	+3	+1	1			2	
Dubois	22	19	—	—					
Floyd	38	38	—1	—2				1	
Harrison- Crawford	14	14	—	+1					
Lawrence	27	25	+1	+2				1	
Orange	10	10	—1	—3					
Scott	4	4	+1	+1		1		2	
Washington	7	7	—	—					
Total	155	150	+3	—	1	1		6	

4th District

Bartholomew- Brown	38	37	—1	—1	1		2	2	
Dearborn-Ohio	19	18	+5	+4			1		1
Decatur	13	8	—1	—3					
Jackson	20	17	+1	+2			1		
Jefferson- Switzerland	24	23	—5	—4			1		
Jennings	9	7	+1	+2				1	
Ripley	9	6	—4	—4				1	
Total	132	116	—4	—4	1		5	4	1


5th District

Clay	14	14	—	—			1		
Parke- Vermillion	24	24	+4	+2				1	

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	ISMA	AMA	ISMA	AMA	Non- Payment	Trans- fer	Deaths	Eligible	Non- Eligible
Putnam	16	16	—	—					
Vigo	120	120	+5	+6			5		
Total	174	174	+9	+8			6	1	

6th District

Fayette-Franklin	19	17	—1	—2			1		
Hancock	22	22	+1	+1			1		
Henry	44	43	+2	+1			1	1	
Rush	16	16	—	+1					
Shelby	18	18	+2	+1				2	
Wayne-Union	77	72	—4	—2	2		4	2	2
Total	196	188	—	—	2		7	5	2

7th District

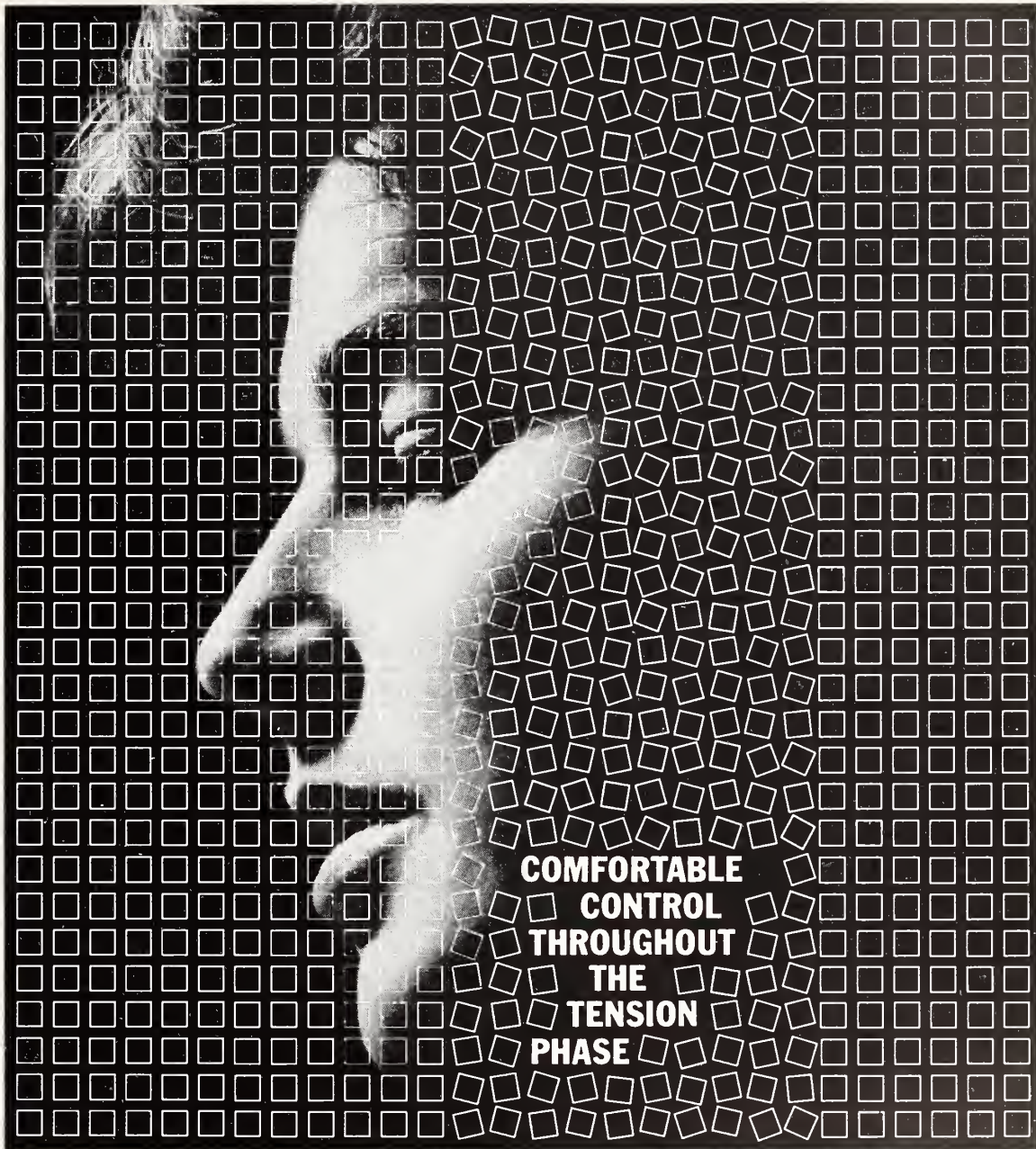
Hendricks	21	21	+2	+2					1
Johnson	33	33	+1	+1			1		
Marion	1072	1070	+4	—2		6	18	45	4
Morgan	17	17	—1	—1	1			1	
Total	1143	1141	+7	—	1	6	19	46	5

8th District

Delaware-Blackford	108	105	—5	+1	2		1	2	2
Jay	16	15	—2	—1					
Madison	108	101	—	—3				2	1
Randolph	23	20	+2	+1			1		
Total	255	241	—5	—2	2		2	4	3

9th District

Benton	9	8	+1	—					
Boone	20	21	—	—			3	2	
Clinton	20	19	—2	—3			1		
Fountain-Warren	15	15	—1	—1		1		1	
Hamilton	24	17	+1	+6			1	1	
Montgomery	30	30	+1	+1				2	
Tippecanoe	108	108	+5	+5	1				
Tipton	11	11	—	—					
White	11	11	—	—					1
Total	248	240	+5	+8	1	1	5	6	1



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	ISMA	AMA	ISMA	AMA	Non- Payment	Trans- fer	Deaths	Eligible	Non- Eligible
10th District									
Jasper- Newton	14	14	—	—				2	
Lake	415	371	+16	+16	2		5	8	3
Porter	25	25	+1	+1				3	
Total	455	410	+17	+17	2		5	13	3

11th District

Carroll	10	10	—	—1					
Cass	42	41	—	+2			1		2
Grant	65	65	+3	+2				6	
Howard	53	52	+2	—			1	1	2
Huntington	22	21	—	—1					1
Miami	21	19	—	—				2	1
Wabash	24	21	—1	—3				1	
Total	237	229	+4	—1			2	10	6

12th District

Adams	15	14	—	—			1		
Allen	264	263	+4	+4			6	5	3
DeKalb	20	18	—1	—1				1	
LaGrange	8	8	—	—					
Noble	20	18	—2	—4			1		
Steuben	13	13	—1	—1				1	
Wells	33	34	—1	—			1	2	
Whitley	17	17	—	—				1	
Total	390	385	—1	—2			9	10	3

13th District

Elkhart	107	103	+1	+3			6	4	
Fulton	10	10	—2	—1		1		1	
Kosciusko	17	17	—	—			1	1	
LaPorte	92	89	+3	+3		2	1	2	
Marshall	23	22	+1	—					
Pulaski	8	7	+1	+1					
St. Joseph	231	231	+9	+9	1		4	5	1
Starke	6	6	—	—				1	
Total	494	485	+13	+15	1	3	12	14	1

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	ISMA	AMA	ISMA	AMA	Non- Payment	Trans- fer	Deaths	Eligible	Non- Eligible
SUMMARY									
1st District	277	270	+1	+2	1		1	11	1
2nd District	151	136	+1	+4	1		3	2	
3rd District	155	150	+3	—	1	1		6	
4th District	132	116	—4	—4	1		5	4	1
5th District	174	174	+9	+8			6	1	
6th District	196	188	—	—	2		7	5	2
7th District	1143	1141	+7	—	1	6	19	46	5
8th District	255	241	—5	—2	2		2	4	3
9th District	248	240	+5	+8	1	1	5	6	1
10th District	455	410	+17	+17	2		5	13	3
11th District	237	229	+4	—1			2	10	6
12th District	390	385	—1	—2			9	10	3
13th District	494	485	+13	+15	1	3	12	14	1
Total	4307	4165	+50	+45	13	11	76	132	26

2. *Remission of state dues.* The Council voted remission of state dues as follows:

LaGrange County—One member, because of illness and financial hardship, on motion of Drs. Kintner and Vye.

Lake County—One member, because of illness and inability to practice, on motion of Dr. Challman, duly seconded.

Marion County—Two members, one due to illness and subsequent retirement, and one who is on a five-year tour as a medical missionary in Africa, on motion of Drs. Everly and Paris.

Putnam County—One member, because of disability, on motion of Drs. Wiseman and Vye.

St. Joseph County—One member, because of illness and financial hardship, on motion of Dr. Kintner, duly seconded.

New Business

1. *Conference on Aging.* The chairman of the Council and Dr. A. C. Offutt, state health commissioner, reported on their attendance at the Conference on Aging, held in Washington on January 6.

2. *State Board of Health Matters.*

A. RHEUMATIC FEVER PROPHYLAXIS PROGRAM. Dr. Offutt reported that the postal card poll of physicians indicated that 59.1% of those who returned the cards preferred an injectable penicillin product and 24.9% wanted daily oral penicillin. "We are asked now to consider the addition of oral penicillin and oral sulphadiazine to the existing program of rheumatic fever prophylaxis. These are products which we will purchase and which the physician then can get for a patient."

On motion of Drs. Neumann and Challman, the Council approved the addition of oral penicillin and oral sulphadiazine to the rheumatic fever prophylaxis program.

B. RHEUMATIC FEVER REGISTRY. Dr. Offutt asked for the opinion of the Council on the establishment of a rheumatic fever registry follow-up program with respect to patients receiving prophylaxis. "It is not sufficient to have only names in a registry. We should have some sort of a follow-up program with respect to the patients who receive prophylaxis for rheumatic fever. In other words, we know now that they're getting it. We don't know what happens after that. We would like to set up this registry if there is no objection to that sort of thing."

On motion of Drs. Wilder and Paris, the Council approved of a follow-up registry for rheumatic fever patients.

C. SURVEY ON HOSPITAL USE. Dr. Offutt explained that the National Office of Vital Statistics is asking permission to make a survey in Indiana to derive estimates on hospital utilization by deceased persons during the 12 months prior to death. "Presently they are getting some of this information out of the Health Interview Survey, and they compile that for the living. . . . This mortality survey might be of benefit since it will add to the statistical information on hospital usage which is not presently being gathered under the Health Interview. The design of the survey is this: they will take a national sample of 3,000 deaths in 1961; they will query the hospitals where the patient may have died, or the family informant, whichever applies at the place of death; then they will list the hospital that the informant gives them in which the decedent has been



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hospitalized in the last 12 months of his life, get information on details of that hospitalization. . . . Indiana's portion of the 3,000 will be only 84 such deaths to be investigated." Dr. Offutt discussed two sample forms to be used, one for family and one for hospital information.

On motion of Dr. Paris, duly seconded, the Council approved of a pilot study, as outlined by Dr. Offutt, on hospital usage.

D. NURSING HOME REGULATIONS. Dr. Offutt discussed the patient-physician relationship of nursing home patients in connection with the State Board of Health's regulation that to be admitted to a nursing home a person must have a physician's diagnosis. "This has caused some trouble. On our inspections we ask what is the matter with patient A, and there is a place on our form where that diagnosis is listed. Now someone, I don't have any idea who, complained to the AMA, saying that we were inserting ourselves into a privileged relationship and disturbing it. Our feeling in the matter was actually to aid and to protect the patient and to aid the physician. . . . I am prepared now to tell you that in order to reduce any possible friction in the future we will not copy down the diagnosis; we will simply have a column which lists an MD diagnosis and then if our nurse inspectors find a diagnosis they will put a check mark. . . . I have not heard any more about this from the AMA so maybe we have satisfied them."

E. TUBERCULOSIS CONTROL. The following resolution, proposed by the Commissions on Public Health and on Voluntary Health Agencies, was discussed by Drs. Offutt, Paris, Edwards and Rifner:

BE IT RESOLVED, that the members of the Indiana State Medical Association continue to accept the responsibility for a practical program for the prevention, control and eradication of tuberculosis in Indiana, and welcome cooperation from official and non-official health agencies directly concerned in accomplishing the task, and

BE IT FURTHER RESOLVED, that the members of the Indiana State Medical Association are in accord that the application of chemo-therapy is one essential in the elimination of tuberculosis as an endemic disease, and

BE IT FURTHER RESOLVED, that the Council of the Indiana State Medical Association admonishes its various Commissions to continue cooperative efforts to work out a plan to accomplish these objectives, offering in the end, guidance to county medical societies in establishment of programs at the county level.

On motion of Drs. Paris and Rifner the Council voted to instruct the Commissions to proceed on the basis outlined in the resolution.

F. LICENSURE OF NURSING HOMES. Dr. Offutt said reports had not yet been given to the secretaries of the county medical societies on licensure of

nursing homes in their areas, as requested by the House of Delegates at the French Lick meeting, but his department was working on this and copies of the survey would be sent out in due time.

3. Liaison Committee on Mental Health. Dr. Stewart T. Ginsberg reported on the various meetings he had attended as a representative of the Indiana State Medical Association on the Liaison Committee on Mental Health. He spoke of the emphasis being placed on bringing closer together organized medicine and the state mental health authorities and directors of the state mental health program, and the important role that organized medicine has in the mental health program and in the treatment and rehabilitation of hospitalized mental patients.

Speaking as a member of an ad hoc committee of the Surgeon General, Dr. Ginsberg said: "Here, too, we are emphasizing less the large state mental hospitals and more the family physicians in the local communities, with all of their resources, including the general hospital. As you know, the general hospitals are assuming a far greater role in the treatment and rehabilitation of the mentally ill than ever before. This ad hoc committee report will be issued soon; it will be merely a guide to the states to implement plans for a program, or not, as they see fit.

"Recently I have been appointed to another ad hoc committee, with Dr. Felix of the National Institute on Mental Health, and again I'm sure we will come up with more emphasis on going back into the community in diagnosis, evaluation, treatment and rehabilitation of the mentally ill. This is going to depend a great deal on organized medicine and all of the other agencies that are involved. I certainly hope that in the future we will have the kind of wonderful cooperation that I have seen here in Indiana between Mental Health, the State Board of Health and organized medicine. The Mental Health movement must fit into a medical co-operative effort, because this is needed so badly to accomplish our mutual goals."

4. Grievance Committee. Dr. Philip B. Reed, chairman, reported as follows:

A. LETTER FROM AMA MEDICAL DISCIPLINARY COMMITTEE. At its November 13, 1960, meeting, the Grievance Committee voted to defer action on this matter until the AMA's nationwide survey of the problem is completed and the results are available to the groups designated by the House of Delegates, which accepted and passed the Reference Committee's recommendation. "The Grievance Committee felt that in light of our present day ignorance of the matter we were in no position to propose to the Council at this time that legislation be submitted to the Indiana State Medical Association legal counsel, and in turn, to be submitted for consideration by the General Assembly currently in session. I have talked with Francis Land, chairman of the Commission on Medical Education and Licensure, and he has agreed, and to Dr. Pete Lamey of the State Board of Medical Registration and Examination, who likewise thinks that nothing

should be done. In fact, Dr. Lamey seriously questions if there is need for legislation. We are simply reporting as a matter of information."

B. Dr. Reed asked for advice on two cases which his committee has been unable to close in accordance with the rules and regulations under which the Grievance Committee has operated since it was established in April, 1952. These cases were discussed by Drs. Eades, Reed, Stimson and Vye, and it was agreed that the County society involved would take the necessary action to close these two cases.

5. *Commission on Voluntary Health Agencies.* Dr. Norman Booher, chairman of the Commission on Voluntary Health Agencies, appeared before the Council to report on the activities of his Commission with the recognized voluntary health agencies. He spoke of the proposed legislation which would require voluntary health agencies to register each year, and the proposed criteria for official recognition of voluntary health agencies by the Indiana State Medical Association, both of which had been presented in meeting with the voluntary health agencies and copies of which were supplied each councilor. "These agencies seemed to feel a need, from their point of view, for such regulation, perhaps on a voluntary basis, if we did not want to make legislation out of it.

"The proposal at the present time is this: The voluntary health agencies are offering to create a Council, probably to be called the Council on Voluntary Health Agencies, and, subject to our approval, will set up the ground rules that will do this. They will meet each year, and report to the Commission on Voluntary Health Agencies of the ISMA the necessary data, financial, research and otherwise. They will be approved or disapproved by the ISMA under this list of criteria for official recognition of voluntary health agencies.

"Do you approve of the ISMA putting itself in the position through the Commission, of saying 'Yes' or 'No' to the efforts of the voluntary health agencies in this state annually? . . . This will mean, of course, that the members appointed to this Commission each year will be taking on a tremendous job, in time and responsibility, to approve these organizations. . . . We need approval of this set of criteria and perhaps some expression as to how far we are going with this thing, so far as our meeting with these people on January 29th is concerned. Our recommendation at this time is that we be authorized to go ahead and proceed with the voluntary Council in order that they police themselves by submitting their reports to us and that we be put in the position to judge the organizations from their own reports, rather than to introduce legislation.

"The first question, gentlemen, is whether we accept this on a voluntary basis, and second, we would like to know specifically what you think about this criteria."

Discussed by Drs. Cavins, Owsley, Paris and Kerr.

On motion of Drs. Paris and Kintner, the Council accepted the criteria as presented by Dr. Booher and instructed the Commission on Voluntary Health Agencies to proceed on a voluntary basis.

6. *Commission on Medical Economics and Insurance.* The executive secretary reported that two or three different insurance programs had been referred to this Commission for investigation and study, with the result that the Commission on Medical Economics and Insurance has recommended that the Council reaffirm its previous position of not approving any one carrier for insurance in the State of Indiana.

It was taken by consent that the previous action of the Council is a matter of established policy and reaffirmation was not necessary.

Amendment of Bylaws regarding dues payment. **On motion duly made, and seconded by Dr. Vye, the Council voted to recommend to the Commission on Constitution and Bylaws that Section 12 of Chapter XXVI of the Bylaws be amended to read as follows:**

"and those elected to their first membership after October 1 of any one year shall pay 50% of the total regular dues as dues for the remainder of that year."

This Bylaw presently reads as follows:

"and those elected to their first membership after October 1 of any one year shall pay \$10.00 as dues for the remainder of that year."

Dr. John D. Van Nuys, dean, I.U. School of Medicine, reported that the first unit of a teaching hospital had been included in the state budget and had been approved by the State Budget Committee, the outgoing Governor, and the incoming Governor, and if the budget is not too tight he has been assured that this hospital will materialize. "We appreciate very much the support that the State Medical Association has given us here, and I think if we play it honestly and squarely, with both our local colleagues and with those of you out in the State, that we will be deserving of your support and hope it will be continued."

Dr. Van Nuys also discussed the National Defense scholarship fund program, reporting that there are 14 or 15 such scholarships at the I. U. School of Medicine.

By consent, the Council instructed the executive secretary to send the greetings and best wishes of the Council to Dr. Cleon Nafe, who is ill.

Spring Meeting of the Council

By consent, Sunday, April 9, 1961, was set for the spring Council meeting.

There being no further business, the meeting was adjourned. ◀

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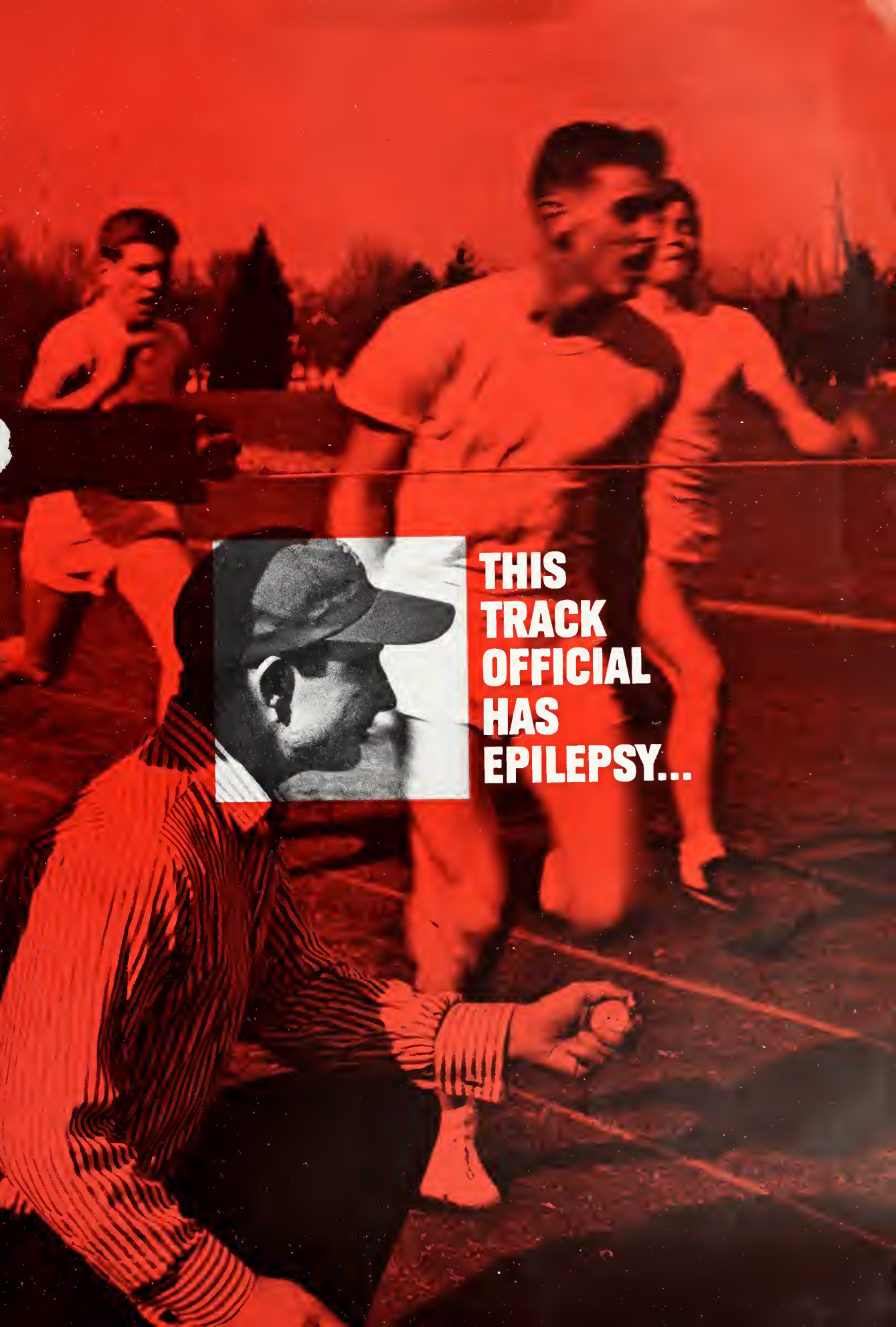
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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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Your Cholesterol Depressant Diet Book

Menu plan for

Mrs. John Doe
DATE Feb. 1961

JOSEPH ROE

M.D.



1200 CALORIES		1500 CALORIES		1750 CALORIES	
breakfast 1/2 cup skimmed milk 1 egg Coffee or tea with 3 drops, skim milk TOTAL 330		breakfast 1/2 cup skimmed milk 1 egg Coffee or tea with 3 drops, skim milk TOTAL 330		breakfast 1/2 cup skimmed milk 1 egg Coffee or tea with 3 drops, skim milk TOTAL 330	
lunch 4 oz. tomato juice 2 oz. ground tuna fish, surrounded with raw vegetables with 1 tbsp. French dressing 1 1/2 water Coffee or tea with 3 drops, skim milk TOTAL 330		lunch 4 oz. tomato juice 2 oz. ground tuna fish, surrounded with raw vegetables with 1 tbsp. French dressing 1 1/2 water Coffee or tea with 3 drops, skim milk TOTAL 330		lunch 4 oz. tomato juice 2 oz. ground tuna fish, surrounded with raw vegetables with 1 tbsp. French dressing 1 1/2 water Coffee or tea with 3 drops, skim milk TOTAL 330	
snack (May be had at mid-afternoon or evening) 8 oz. skim milk TOTAL 90		snack (May be had at mid-afternoon or evening) 8 oz. skim milk TOTAL 90		snack (May be had at mid-afternoon or evening) 8 oz. skim milk TOTAL 90	
dinner *2 1/2 portions Pickled Beet and Cucumber Salad *1/2 Baked Chicken Breast *Baked Asparagus 1 roasted potato half Coffee or tea with 3 drops, skim milk TOTAL 330		dinner *2 1/2 portions Pickled Beet and Cucumber Salad *1/2 Baked Chicken Breast *Baked Asparagus 1 roasted potato half Coffee or tea with 3 drops, skim milk TOTAL 330		dinner *2 1/2 portions Pickled Beet and Cucumber Salad *1/2 Baked Chicken Breast *Baked Asparagus 1 roasted potato half Coffee or tea with 3 drops, skim milk TOTAL 330	
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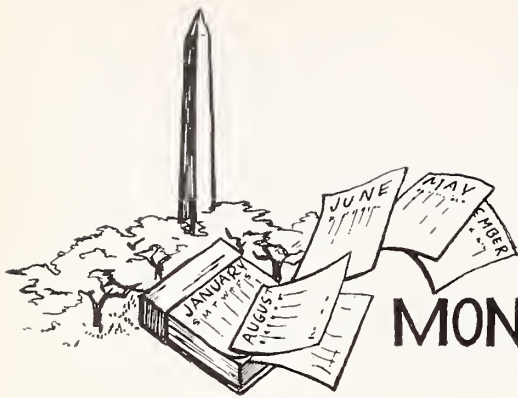
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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—The American Medical Association branded as untrue certain statements by Abraham Ribicoff, Secretary of Health, Education and Welfare, concerning the Administration's legislative proposal to provide medical care for the aged under Social Security.

Dr. F. J. L. Blasingame, AMA Executive Vice-President, presented a point-by-point rebuttal in a letter to the more than 500 editors from throughout the country after Ribicoff addressed the annual meeting of the American Society of Newspaper Editors in Washington.

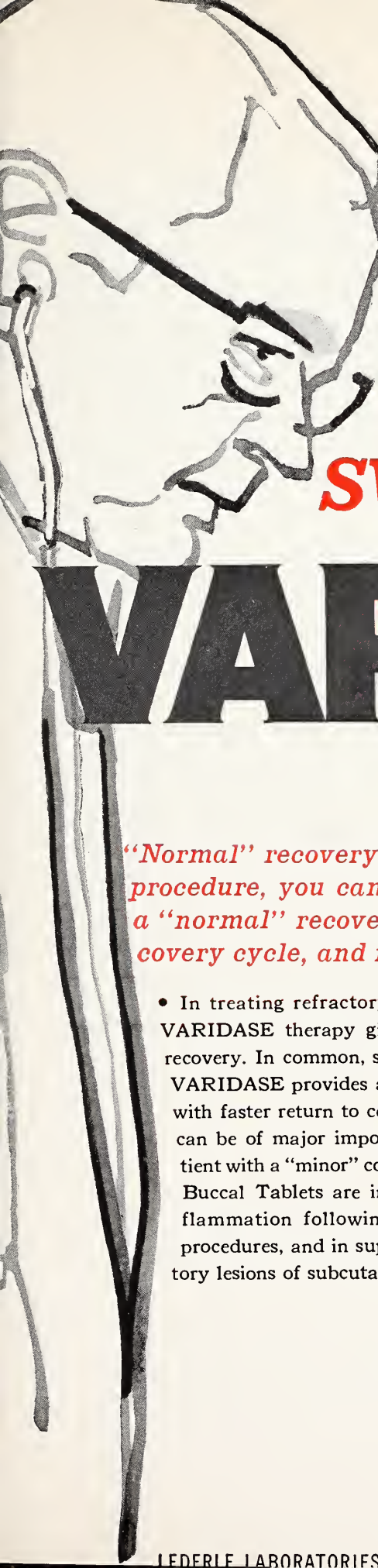
Dr. Edward R. Annis, Miami surgeon representing the AMA, accused Ribicoff of misrepresenting the role of doctors under the administration proposal. Dr. Annis answered Ribicoff on a radio-television program with Sen. Kenneth B. Keating (R.-N.Y.) which was taped in Washington. Ribicoff had made the misrepresentation on an earlier Keating program.

Dr. Blasingame said Ribicoff's statement before the editors that physicians are not included in the administration proposal, the King bill, "simply is not true." The AMA official pointed out that the bill includes interns and residents in teaching hospitals as well as pathologists, radiologists, psychiatrists and anesthesiologists working in hospitals or serving hospitals' outpatient clinics.

"Mr. Ribicoff further claims that the King bill provides free choice of hospital physician," Dr. Blasingame said. "The fact is only hospitals signing contracts with the federal government would be available to patients. If the only hospital in a community was not approved by the Secretary of HEW, patients in that community would be forced to seek hospitalization in some other city. That would not afford free choice of hospital. If the patient's physician was not on the staff of the other hospital, the patient would be denied free choice of physician."

Dr. Blasingame also disputed Ribicoff's contention that the King bill is not socialized medicine.

Continued



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MONTH IN WASHINGTON

Continued

"By common definition, any scheme which calls for a system of compulsory health care which is administered, financed, and controlled by the federal government is socialized medicine for that segment of the population it serves."

Rep. Walter H. Judd (R., Minn.), who is a physician, was quoted as one of a number of House and Senate members who agree with AMA: "The public has been led to believe that they can get government financing without government control and ultimate government operation of medical services. It is naive for anyone to believe that Congress will take the people's money away from them through taxes and then allow the money to be spent by someone else without the Congress maintaining its own firm control."

Pointing out that the nation's physicians always have been in favor of medical care for all, regardless of ability to pay, Dr. Blasingame said:

"It seems strange to us that Mr. Ribicoff continues to lobby for the King bill while completely ignoring the Kerr-Mills law, passed by Congress last year with strong support by the nation's physicians.

"The Kerr-Mills law enables the states to guarantee to every aged American who needs help, the health care he requires. And the states are implementing the law with unprecedented swiftness."

Dr. Annis pointed out on the radio-television program that "doctors would work for the government by working for the hospitals under contract to the government." He said those doctors would work "under rules, regulations and controls prescribed and laid down" by the HEW.

KREBIOZEN EVALUATION

The Department of Health, Education and Welfare has agreed to make an impartial evaluation of the controversial cancer drug Krebiozen.

U. S. District Judge Julius H. Miner of Chicago requested the evaluation before proceeding with a \$300,000 libel suit filed by Andrew C. Ivy, M.D., a leading endorser of the drug, against George D. Stoddard, Ph.D., chancellor of New York University and former president of the University of Illinois.

In a letter to HEW Secretary Ribicoff, Miner said:

"In my humble judgment, Krebiozen has too long been a controversial subject and the American public deserves that it be examined under neutral supervision and by the most competent experts in whom the people have implicit confidence."

Ribicoff said the National Cancer Institute would evaluate the drug when its sponsors presented the necessary data. But, he said, "any decision to undertake a study with human cancer patients must await, and depend on, the results of the evaluation of the existing clinical data."

Continued

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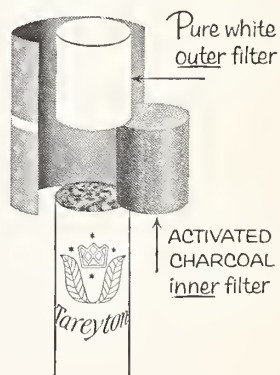
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PHYSICIANS' RETIREMENT

A new bill to encourage physicians and other self-employed persons to set up their own retirement plans started through Congress with approval of the House Ways and Means Committee.

Bearing the same number, H.R. 10, as a similar bill which died in Congress last year, the new measure would permit a self-employed person to defer taxes on income placed in a private retirement program. The special treatment would be limited to \$2,500 or 10 per cent of income each year, whichever is smaller.

Such income could be invested in qualified pension trusts, annuity programs, profit-sharing plans or a new type of non-transferable government bonds redeemable when the individual reaches retirement age or suffers disability.

An individual could start drawing benefits at age 59½, or earlier in the case of disability. A self-employed person would have to start drawing benefits by age 70½.

If a self-employed individual had more than three employees, he would be required to set up pension plans for them before he could benefit himself.

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**How you can help save
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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Compulsory Medical Program

As far as government medical aid for the aged is concerned, let us agree that a good many elderly people need help to meet costs of catastrophic illness. Let us agree, too, that providing selective assistance is an honorable thing for government to do.

But let us ask the President and Congress this question: Why is it that so many government aid programs—like the expanded medical care Mr. Kennedy is now proposing—plan to pay out taxpayers' money to persons who can afford to meet their own medical needs? Why, if government is to come to the aid of people, should it not limit its aid to those who actually are in need?

There are some elderly citizens who can afford to pay their own expenses, and some whose children can well afford to provide their medical needs. Why should the taxpayers foot these bills as well as the bills for the really needy?

The Kennedy proposal is for medical care for everyone—the self-reliant as well as the indigent. With the government so hard pressed for money and running so deeply in the red, one would think that it would not have the funds to pass out to the well-to-do as well as to the hard-up. But this is what the government does in other programs—it distributes benefits not only to those in need, but also to those not in need. This seems a strange way for the government to get out of debt.

The compulsory feature of the new Kennedy program would require participation by millions who are already amply protected by—and who prefer—private health plans. Why extend the federal medical care plan to these individuals, who are already protected, when that money could be saved? Why not make the medicare program one of voluntary participation?

It is one thing for the government to see that all elderly people have the medical attention they need. But there are still people who want to work out some of their problems themselves. The push to place all medicare for the aged under social security will be one more move towards making the government wholly responsible for all the needs of the people.

Every time the government takes over some function of so-called public need, it means more money from somewhere. Some of these needs are real and should be faced. Others are urged for political reasons. But there is getting to be too much compulsion in putting some of the programs into effect.

Kokomo Tribune
Feb. 15, 1961

One in Three Isn't Enough

The American Cancer Society reports that one out of three cancer patients is now being saved because of new detection and treatment methods and, possibly most important, early diagnosis. More than a million Americans are alive today, five years or more after they started treatment.

But one out of three isn't good enough. The immediate goal is one out of two. Judging by present trends, one million children now in school will die of lung cancer before they are 70. In 1961, some 37,500 people will die of this type of cancer. Fourteen thousand women will die of uterine cancer which, if caught early, is nearly 100% curable.

These figures are enough to impress on us all the continuing necessity for supporting the Howard County Cancer Unit in its annual fund crusade which opened Saturday.

Continued

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References: 1. Lineback, M.: The Eye, Ear, Nose and Throat Monthly 39:342 (April) 1960. 2. Fuchs, A. M. and Maurer, M. L.: New York J. Med. 59:3060 (August 15) 1959. 3. Kreindler, L. *et al.*: Antibiotic Med. and Clin. Therapy 6:28 (January) 1959. 4. Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478 (September 3) 1959. 5. Edmonds, J. T.: The Laryngoscope 69:1213 (September) 1959. 6. Horstman, H. A.: Am. Pract. & Digest Treat. 10:96 (January) 1959.

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FOURTH ESTATE

Continued

Great efforts are going on constantly to find what causes the various forms of cancer and what can be done to prevent and control the disease. Most of us are aware of the dedicated scientists and doctors who are working so earnestly to discover the secret of cancer.

This research is financed partly by what we as citizens give to the cancer fund drive. Since cancer is a threat to every family, everyone who can spare a contribution should give it cheerfully. Even eagerly.

The wonderful research programs that are in progress in many laboratories are being waged for us. We can show our gratitude by adding something to the funds needed.

Let us also appreciate the public education programs of the cancer society—the reminder of cancer symptoms for which everyone should be looking and which often appear early enough to save lives. The cancer organization couples its information on symptoms with advice to have at least one medical check-up a year, and that is something everyone should heed.

Kokomo Tribune
Apr. 4, 1961

The Really Tragic Time Gap

Often you hear scientists in many fields speak feelingly of the time lag that usually exists between the appearance of marvelous new discoveries and their wide use by the people they can benefit.

But the really tragic time gap is in health, for there the costly lag spells death, disease and physical handicap—unnecessary in so many instances. Many of the millions of dollars fruitfully spent on medical research are not translated into bolstering health and saving life.

To dramatize this problem, the Public Health Service has put out an illustrated booklet setting forth its severe human cost.

There are said to be at least 40,000 needless cancer deaths a year. If all current knowledge were applied, we'd save 120,000 cancer patients annually, instead of 80,000. And millions in hospital bills and lost income would be saved.

Preventable attacks of rheumatic fever and rheumatic heart disease kill 20,000 annually. Simple, prompt treatment of throat infections that lead to these ailments can block them.

The nation has 500,000 mentally ill people who fill half our hospital beds. Yet mental health clinics, guidance services and psychiatric aid could nip many such illnesses in the formative stage. And new drugs and methods of care can shorten the time the mentally ill need to spend under institutional care.

Glaucoma and diabetes account for a fifth of all cases of blindness. Yet surveys show that a million persons with glaucoma and a million and a half with diabetes get no treatment at all, because they don't even know they have these ailments. They are recruits for the ranks of the blind. Easy tests can determine whether a person has either of these conditions.

We could be close to wiping out tuberculosis as a big health problem. Nevertheless, we still have 60,000 new cases and 12,000 deaths every year because treatment is either inadequate or is broken off.

Though the Salk vaccine has existed in ample supply for years and the total of polio cases has dropped dramatically, 6,000 persons were paralyzed by this disease in 1959. Surveys show a high percentage of low-income families are not vaccinated. Nearly half the victims are under five years of age.

To wipe out the costly time lag, the PHS urges you and your community to make the fullest possible use of: immunization against preventable disease; periodic checkups; rehabilitation programs for the chronically ill and disabled; trained health personnel and facilities.

Millions suffer and die who need not. If this painful, costly loss is ever to end, they must act—in time—to help save themselves.

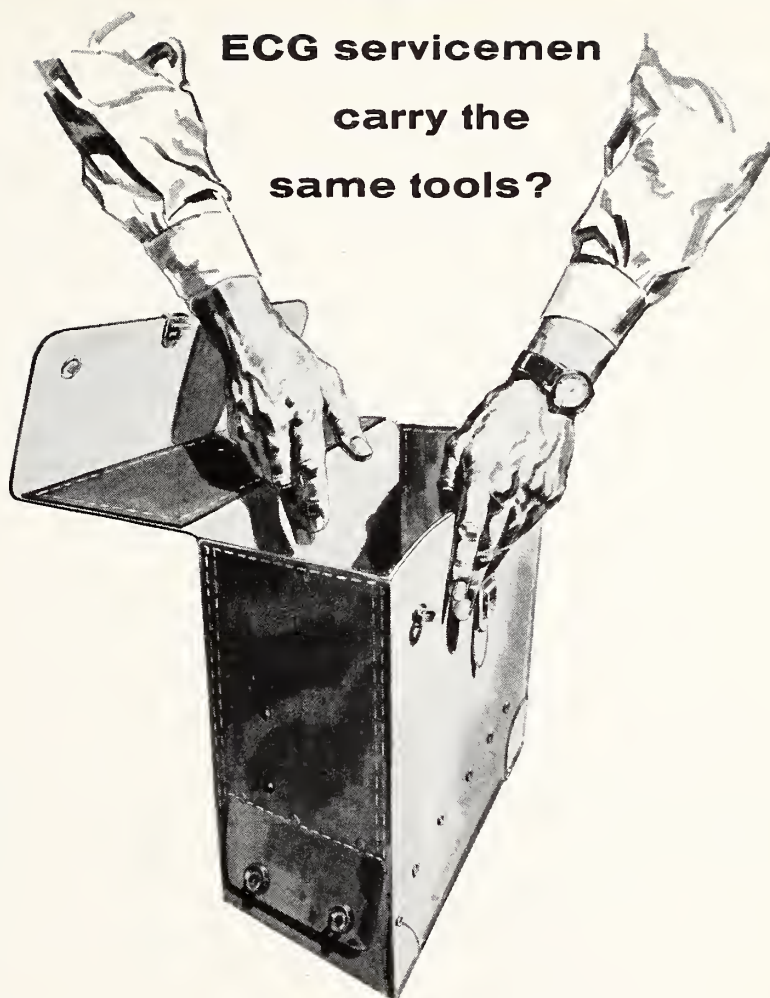
Kokomo Tribune
Apr. 18, 1961

If Six Signs Would Be Obeyed

There are at least six "life-savers" which, if properly used, would substantially reduce the heavy loss of life and property resulting from highway auto crashes, suggests the Indiana Traffic Safety Foundation.

These are the six basic traffic signs used along our streets and highways. The shape and design of traffic signs represents the expert thinking of traffic engineers and safety officials from throughout the nation. The foundation estimated that, in 1960, six out of every 10 drivers in-

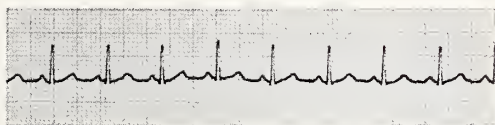
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FOURTH ESTATE

Continued

volved in fatal accidents violated some visible reminder of the law. Drivers continue to get killed or hurt because too often they disobey, don't see, ignore or don't understand traffic signs, signals and markings, says Albert E. Huber, executive director of the foundation.

The foundation urges all motorists to learn the six traffic signs by shape so that they can readily recognize them on sight:

1. Octagon . . . red with white lettering. Means come to a full stop and make sure the way's clear before proceeding. This is a revision of the older stop sign painted yellow with black lettering. But the meaning remains the same.

2. Triangle . . . yellow with black lettering reading "Yield Right of Way." Signifies slow down and stop if necessary to give right of way to cross vehicular traffic or pedestrian.

3. Rectangle . . . white with lettering in black or another color. Indicates traffic laws concerning parking restrictions, speed limits and passing regulations, for example.

4. Round . . . yellow with "X" and "RR" in black lettering. Warns of a highway-railroad crossing 300-500 feet ahead.

5. Diamond . . . yellow with black lettering. Warns of such dangerous or unusual conditions ahead as curves, side roads, intersections, hills, dips, bumps, school zones.

6. Crossbuck . . . tall white railroad sign with black lettering. Usually placed within 15 feet of a highway-railroad crossing.

Kokomo Tribune
Feb. 20, 1961

The Socialist Party in the United States has launched a nationwide campaign for socialized medicine in America and has made it clear it supports President Kennedy's proposal for health care through the Social Security System as the vehicle with which to bring full-blown socialized medicine to this country.

The Socialist Party has also made it clear that it considers socialized medicine merely the first step toward its more ambitious goal—complete socialism of every facet of American life.—AMA News, Mar. 20, 1961

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Medical and Legal Justifications For Autopsy: Should They be Extended?

WILLIAM HAROLD FLEECE, LL.B.

St. Petersburg, Fla.*

“*TO DIE IS ONLY to be as we were before we were born; yet no one feels any remorse, or regret, or repugnance, in contemplating this last idea.*”¹ Stated somewhat similarly, “there was a time when we were not: This gives us no concern—why then should it trouble us that a time will come when we shall cease to be?”²

It may seem peculiar to begin an analysis of the problems relating to autopsy with such quotes, but many facets of the problems involved are largely related to philosophical doctrine. It would be impossible to argue for legal extension of the existing laws in this area without understanding the underlying policy factors affecting such a decision.

Man commonly believes that his conscious being will not end at death, but that it will be continued for an indefinite time or forever, long after “the frail corporeal envelope which lodged it for a time has mouldered in the dust.”² This idea precipitates truly philosophical support to the nature of autopsy. Ethical, moral and religious considerations are the necessary components of such views. These aspects, though not

dramatized, are probably more intrinsic than any other.

In general, it may be stated that autopsy is neither advocated nor disapproved, but rather permitted by most religions in the interest of the betterment of mankind. Noted exceptions are Christian Scientists and Orthodox and Conservative Jews among the major world religions. Certain religious cults may also disapprove.

Religious Beliefs Vary

The Catholic view stated in the *Catechism* is that “the soul is a spirit and will never die . . .” This statement disproves the idea that one can harm the soul by performing an autopsy.

Protestant churches generally adhere to the position that the soul is indestructible and that our external shell or mortal vehicle returns to the dust from whence it came. Regardless of whether one takes the parts of the body and scatters them to the winds or throws them into the seas, God, in His all-power, can still recreate them, if necessary, returning to the dust the breath of life. The Reform Jews’ liberal interpretation of the *Talmud* supports anything serving to promote well-being and curing ill, even to doing an autopsy.

On the other hand, Orthodox and Conservative Jewry is opposed to body preservation and

* Thesis written in partial fulfillment of the requirements for the LL.B. degree, Indiana University School of Law.

autopsy. They interpret the *Talmud* as strictly prohibiting mutilation of a corpse in that it involves disrespect to the dead. In addition, the *Talmud* says that when buried according to Jewish law, every part of the body must be interred. Technically, one cannot take blood or take even the smallest piece of tissue.³

Arguments against this position have been enumerated by Rabbi Leopold Greenwald.⁴ These include a specific device to permit autopsy, a governmental law requiring autopsy, permitting autopsy on a person sick with the same illness that killed another, as cure for the living and as hope to save the children of the deceased, and in the criminal law, to promote evidence. These arguments tend to promote social welfare, as will be discussed later.

The very nature of Christian Science conflicts with autopsy. It teaches that "In the universe of Truth, matter is unknown;" things are thoughts objectified; and we are only spiritual beings. Therefore, an autopsy would do no good, as it is based on material causes which the Christian Scientists believe are illusions.⁵

Whether the objections to autopsy are based on a fear that the immortal soul may be harmed in some manner by a postmortem examination, or whether the allowance of autopsy is based on just the opposite view, viz., no harm will occur to the soul—is perhaps a matter of conjecture. But at least with these basic understandings one can better appreciate the arguments we will later examine.

A Dynamic Picture

Basically, it may be said that an autopsy consists of inspection and thorough study of the external and internal structures of a dead body, for the purposes of establishing, with all possible accuracy, the cause of death and for determining the exact nature and extent of any lesion or other abnormalities. The primary purpose is to acquire facts.⁶ Scientific autopsies are oriented to a realistic reconstruction of the progress of disease as it occurred in the patient while alive. They present the dynamic picture of origin and cause of the disease as altered by all interrelated factors, both intrinsic and extrinsic, operating in a particular host. Autopsies can give the whole known story of the disease process leading to death to as great an extent as is definable in the present status of knowledge.⁷ Records of patients upon whom an autopsy has been performed constitute units of scientific infor-

mation for subsequent studies. Collection of individual records of such patients in hospitals having modern standards, analysis of them by statisticians, geneticists, morphologists, or any other member of the medical profession and reporting of results add to the knowledge of human disease.⁸ Mortality statistics are obviously more reliable if based on autopsy findings rather than clinical impressions. Such data are of vital importance to every individual and to the population as a whole if any attack is to be made on commonly fatal diseases.

One such study, by Dr. Alan R. Moritz and Capt. Norman Zamcheck, involving 40,000 autopsy records at the Army Institute of Pathology between January, 1942, and January, 1946, showed that heart disease was far more frequent in young persons than was commonly believed and was a main cause of sudden death in this group.⁹ From this study medical science advanced. There may be instances where individuals, as well, may be helped. Such was the case of a 15-year-old boy recently seen at the University Hospital, Ohio State University. Physical examination revealed conflicting diagnoses and it was only following an autopsy of the boy's deceased father that the diagnosis of Marfan's Syndrome could be substantiated. The boy was treated adequately from the information gleaned at autopsy.¹⁰

Not a Random Sample

Thus far we have been examining policies concerned primarily with truly medical autopsy as opposed to medicolegal autopsy. Solely from the medical view one may say that all of these arguments, though persuasive, do not yet prove the necessity of further legal extension. This argument may be met by reference to a study at the Cincinnati General Hospital: "The autopsy protocols, microscopic sections and potted gross tissues that have been collected and preserved over a period of several decades, provide a wealth of material research, but there are various biases inherent in the material that can form insidious sources of error for the unwary investigator. The autopsy population does not represent a random sample of the general population of sick people, nor of the totality of fatal cases, in this or any other community."¹¹

This single fact may be a sufficient criterion on which to base extended legal justification and authorization from the medical standpoint, for

no scientist can quarrel with the criterion of ample sampling.

It was pointed out by Dr. Edward B. Smith, citing a study in San Francisco County, Calif., that a *fortiori*, a physician seeing a dead body for the first time and speculating as to the cause of death, was wrong 50% of the time as to actual cause and in error 30% of the time as to the organic system affected.¹³

A side issue, but of great importance, is the further fact that before hospitals can be accredited by the American Medical Association and by the American College of Surgeons, it is necessary that they procure autopsies in 25% of their deaths. If not, they will not be approved for internships and residencies.¹²

Using these examples as but a cross-sectional survey of the medical need for greater autopsy authorization, let us now turn our attention to another facet of the inquiry—the medicolegal autopsy and its related legal problems.

The Medicolegal Autopsy

Medicolegal autopsies differ from true medical autopsies in three general respects: (1) objectives; (2) approach; and (3) authorization.¹⁴

The primary purpose or objective of hospital autopsies is to verify the diagnosis made prior to death and to evaluate the results of treatment. A medicolegal autopsy is essentially an inquiry by society into an unexpected, unexplained death. It may be performed to ascertain whether death was natural or the result of violence. "The ultimate objective is to ascertain facts which may be used to substantiate or to disprove circumstances or conditions indicating legal responsibility."¹⁵ Moritz summarized the function of medicolegal autopsy as follows:

"It should be realized that the medicolegal autopsy is often expected to provide information that would not be looked for in an ordinary hospital case, i.e., information that is important for legal rather than medical reasons. An examination that would meet ordinary medical standards may be so inadequate from a medicolegal standpoint that a murder may not be recognized or an innocent person may be charged with a murder that was not committed. Thus if the pathologist is to avoid mistakes in the performance of a medicolegal autopsy, and particularly in an instance in which homicide is a possibility, he should be aware that in addition to determining the

cause of death, he (and he alone) may have access to information that may be essential in establishing: (1) the identity of the dead person; (2) the time of death; (3) the circumstances in which the fatal injury was sustained; (4) the type of weapon or agent that was responsible for the injury; (5) factors that may have predisposed the victim to injury, or modified the effects of injury; (6) the identity of the person (or persons) responsible for the injury."¹⁶

Evidence derived from an autopsy is likely to have a profound effect on the life, liberty or property of other persons. For these reasons the objectives sought support enforcement of the law and administration of justice. Thus, there have been deaths, seemingly natural when first encountered by a layman or a doctor, which were proved violent only by autopsy.

Again citing Dr. Smith's article, it is seen that "in Georgia, after establishing a crime laboratory and a policy of performing autopsies in questionable cases, in one year, eight entirely unsuspected murders were discovered. Of equal importance, in the same year more than 100 cases were changed from "suspicion of murder" to "natural death."¹⁷ Perhaps we can appreciate the scope and facility of such an approach by the state of Georgia if we refer to a 1921 survey by the Cleveland Foundation: "Indeed we cannot entirely suppress a sense of the ridiculous when we read over the list of causes of death as officially rendered by the coroner of Cuyahoga County for the year of 1919."¹⁸ Following are random selections from the list:

- No. 22942: "Could be suicide or murder."
- No. 22957: "Auto accident or assault."
- No. 22964: "Found dead."
- No. 22987: "Found dead in shanty."
- No. 23035: "Could be assault or diabetes."
- No. 23050: "Premature or abortion."
- No. 23135: "Found dead in alley—Lobar Pneumonia."
- No. 23178: "Aunt said she complained of pneumonia; looked like narcotism."
- No. 23253: "Consider it tuberculosis."
- No. 23484: "Found crushed."
- No. 23551: "Died suddenly after taking medicine."¹⁹

Most remarkable about this survey is that in none of the cited cases was an autopsy per-

formed! It is clear beyond any reasonable doubt that more precise information was needed in these cases, not only to determine the true cause of death but to exclude or uncover criminal activity.

Indications for Autopsy

It is therefore submitted that the most important reason for autopsy in a case of sudden or unexpected death is to determine whether violence in any form, criminal, accidental, or suicidal, has been a factor.

However, there are additional circumstances which influence the selection of autopsy material. One such situation concerns insurance claims. Impending litigation or the prospect of the collection of double indemnity for accidental death prompts relatives to ask for postmortem examinations, a procedure to which they undoubtedly would object were there no insurance. Sometimes the existence of an insurance policy is concealed or denied lest autopsy disclose anatomic changes prejudicial to the beneficiaries' interest.²⁰ Mechanical injuries which destroy life by abolishing the function of one of the important viscera are relatively infrequent. "Most of the lesions found after death are rather the marks of disease than the cause of death."^{20a} Such was the case of an elderly man who died from coronary arteriosclerosis and the family attempted to assert that the deceased had died as the result of an accident a half year prior to death. In discussing autopsy the court said:

"Can anyone doubt that all sentiment would dissipate and all objection would vanish if it were necessary for the estate to make the showing in order to recover the large sum of money involved?"²¹

The correct cause of death may discourage unnecessary and unwarranted litigation. Without autopsy there is too much room for speculation.

When the question of workmen's compensation arises, it is in the interest of both the claimant and the insurance carrier to have the cause of death accurately determined. At the same time there is an opportunity to evaluate the lesions found and correlate their relationship to the alleged occupational accident or injury.²²

Approaches to hospital autopsies and medicolegal autopsies differ in that pathologists conducting hospital autopsies can rely upon the entire medical history and gathered medical data

pertaining to the deceased, whereas in medicolegal autopsy only sketchy information concerning conditions prior to death is ascertainable. The net result is that the approach to the nature of the findings from the postmortem examination is different.

Problems of Authorization

Having dispensed with basic philosophical considerations and medical and medicolegal advantages we turn our attention to the most difficult problem, that of authorization. Statutes in every state empower certain public officials to perform or to authorize autopsies in order to determine the cause of death when the circumstances indicate medicolegal significance. The variance is so great that generalization would be impossible. It may be sufficient to say that the trend of American law seems to be toward increased discretion and increased authorization of autopsies.²³

On the other hand statutes and case decisions in some states limit authority to such an extent that evidence of external violence²⁴ must be present, and that an unlawful act must be suspected or actually known to have caused death. Such statutes and decisions obstruct the very objective of medicolegal autopsy. One objective, that murder shall not escape recognition, is basically affected. Unless the victim has met death through violence resulting in an external wound, foul play may not be suspected.

But what of homicides or suicides due to poisoning? And what of cases of blunt violence where clothing protection prevents obvious injury to the skin but internal organs are ruptured? Often, people who have knowledge remain silent for reasons of self-preservation.

For these reasons justification should be, and in many cases has been extended, for with restrictive legislation, murder could be committed with impunity if the murderer took pains to leave no external markings. "Approximately 10% of all deaths that occur in the United States take place under circumstances such that there is no reliable medical evidence upon which to base a diagnosis."²⁵

Reasons for Restrictions

So the question may be posed, why is there such legal restriction when the facts of a vast number of cases warrant scientific investigation? As we have seen, there are but few religious ob-

jections. This leaves us to speculate that the answer may be ascertained only by combining several variables. Undoubtedly there is some aura of psychological objection since people are basically squeamish about the thought of cutting up dead bodies.

Combining this factor with early historical views of body sanctity we should clearly see that early legislatures necessarily restricted authorization to the bare minimum of necessity—that, of course, being crime. Since the law often dogmatically follows precedent and *stare decisis*, as if it were some divine guidepost, it is not hard to theorize that the law soon evolved into a state of practical rigidity, especially in an area where resistance could be expected. The courts' language in numerous cases clearly manifests the absolute reservation with which the courts approached legal justification. Several cases are noteworthy.

One dissenting judge said:

"No one doubts the dislike of the family for the disinterment and cutting up of the body of a loved one. It is at best a ghoulish proceeding which should be tolerated only when it is resorted to promptly, when it is free from any taint of improper use for settlement purposes, and when the ends of justice clearly demand it."²⁶

I would like to pose the obvious question to this dissenter. What are the "ends of justice" and how can you say they are not "clearly demanded?"

Another court dismissed the request for an autopsy with, "Here we have no clear or convincing showing that an autopsy would in all reasonable probabilities disclose the information sought."²⁷ Perhaps the only reasonable showing could be made on postmortem!

Many courts take advantage of principles of strict statutory construction to avoid autopsy. One particularly interesting case construing *Mo. Stat. Ann.*, §§ 11608, 11612 reported:

"Of course it is beyond the realm of probability that the legislature ever intended to confer upon a coroner the right to perform an autopsy in any case that in his judgment he might deem proper, for this would empower him to enter the homes of our citizens indiscriminately and over their protests remove corpses under any circumstances, regardless of the cause of death, provided that the coroner

thought an autopsy, in a particular case, would further the advance of science or some purpose believed desirable to him."²⁸

I submit that this is a rather extreme position.

Avoid Statutory Prerogative

As radical a position as the previous case are the cases which could rely on statutory authorization but talk of waiver or other means to avoid the statutory prerogative.

A two months' delay in an effort to procure an autopsy has been held a waiver of right.²⁹ Similarly, in a subsequent Indiana case in which the autopsy was requested pursuant to a workman's compensation statute, the board denied authorization asserting that the intervening 3½-month period from the time of death to the request for autopsy constituted a waiver. The most amazing feature of this case is that the requesting party had just received notice that the claim was pursuant to a statute providing: "The employee or the industrial board shall have the right in any case of death to require an autopsy."³⁰

What is the reason for such a holding? The answer here is precedent, for an early Indiana case stated, "we do not believe that it was the intention of the legislature that an autopsy could be demanded in every case of death. Such a construction would render the provision unreasonable where the cause of death is clearly apparent without it, where the cause of death is not uncertain, and is not in dispute."³¹

Of course I submit that there may be cases where the cause of death is absolutely certain, thereby eliminating the necessity for an autopsy, e.g., where the decedent has suffered approximately 21 wounds and had his skull cracked, and considerable blood had been found at the scene of the assault.³² But still it would seem in the best interest of forensic science to depend on postmortem examination for evidence.

Inconsistency and Injustice

The most striking case encountered reeks of injustice. A Kansas county attorney filed an information charging the defendant with inflicting mortal wounds upon the deceased with his fists and a blunt instrument. No autopsy was performed. The death certificate stated: "Injuries—unknown cause." "How did injuries occur?—During fight with man." Defendant was tried and convicted. On appeal the Kansas

Supreme Court affirmed, construing the Kansas statute *Gen. Stat. 19-1003 (1949)* to mean that "the coroner shall hold an inquest upon the dead bodies of such persons only as are supposed to have died by unlawful means where the cause of death is unknown. Here the cause of death was known and no inquest was necessary."³³ Is such a holding consistent with the ends of justice? I submit it is not.

The above example shows a possible abridgment of another objective of the medicolegal autopsy—protection of innocent persons from unjust accusations. As of 1942 it was Moritz' thesis that 10 million people were injured in the U. S. each year and that by the law of chance some will have died from injury. Cause and effect may not exist but then again it may. Autopsy is the only answer and without it injustice of administration of both criminal and civil law results.³⁴

Fortunately, not all of the courts take such a dim view of postmortem. Liberal interpretation of a statute may lead to a holding that the facts of the case permit the coroner to exercise discretion.³⁵ Further, if the "interests of justice demand it"³⁶ this is sufficient. The autopsy has even been referred to as an act of paramount public authority,³⁷ or an official right³⁸ by some realistic courts. Wigmore asserts that "the exhumation or the autopsy of a corpse, when useful to ascertain facts in litigation, should of course be performed. Reverence for the memory of those who have departed does not require us to abdicate the high duty of doing justice to the living."³⁹

In line with the preceding is the view that autopsy is the proper subject of a legal discovery procedure. A showing of good and substantial reason would permit autopsy to be performed where the evidence is considered vital to the controversy.⁴⁰

All of these arguments seem reasonable when we reflect that courts are instituted to promote justice, ascertain truth and protect life, liberty and property. "To fairly and rightly accomplish these purposes, the supreme desire and purpose is, and in every case should be, by every consideration and fair rule, to ascertain the very truth of the matter in controversy, and by such rules of evidence as will, in this nature, accomplish this result."⁴¹

If such disclosures cannot be made, it is be-

cause of the rights of the parties to disclose the truth, if believed advantageous, and to conceal it if believed harmful and this ought not be a rule for the guidance of the courts.⁴²

Laws Should Provide Authority

As a basic deduction it may now be asserted that the law should provide those public officials responsible for the investigation of death with the needed authority and power to perform or order performance of autopsy in any instance when the interests of public welfare demand it. As indicated previously the trend of American law is toward that end.

One state has done such a magnificent statutory job that I deem it advisable to set out the statutory provision as an example of the type of coverage that should be attained:

"It shall be the duty of the coroner either to hold an inquest, to view the body, or to make an investigation in all cases of suspicious, unexpected, unusual deaths, sudden deaths, violent deaths, deaths due to unknown or obscure causes or in any unusual manner, bodies found dead, deaths without attending physician within 36 hours prior to the hour of death, any case of suspected abortion whether self-induced or otherwise, deaths due to suspected suicide or homicide, deaths in which poison is suspected, any death occurring in a hospital under (sic) 24 hour (of) admission, unless seen by a physician in the last 36 hours, death following an injury or accident either old or recent, deaths due to drowning, hanging, burns, electrocution, gunshot wounds, stabs or cutting, lightning, starvation, radiation, exposure, alcoholism, addiction, tetanus, and from strangulation, suffocation, or smothering, deaths, to trauma from whatever cause, premature births, stillborn deaths, deaths due to criminal means or by casualty, deaths in prison or while serving a sentence, deaths due to virulent contagious disease that might be caused by or cause a public hazard, and in all cases of alleged rape, simple or aggravated, carnal knowledge and crimes against nature. . . . The coroner is authorized to perform or cause to be performed by a competent physician, an autopsy in any case in his discretion. The coroner or the district attorney each shall have the authority to order the disinterment of any dead body within the jurisdiction . . . and to authorize the removal of such dead body . . .

for the purpose of examination and autopsy. . . . The coroner may hold any body of a dead person for any length of time that he deems necessary, and he shall be empowered to remove and retain for tests and examination or other purposes, any portion of the remains that he may think advisable or needful for future use. Following autopsy the coroner may retain any specimens or organs of the deceased, which in his discretion are desirable or needful for anatomic, bacteriologic, chemical, or toxicological examination, as well as for possible evidence before a grand jury or court. . . ."⁴³

The preceding statute certainly makes it easier to fulfill the objectives of medicolegal autopsy. In addition there are statutes which provide the medical profession with unclaimed bodies for scientific purposes, viz., postmortem dissection.⁴⁴ This enlarges and simplifies authorization from the medical standpoint. Consistent with that position and equally effective are statutes extending the consent necessary for an autopsy. A prime example is Colorado where a new autopsy law was introduced into the legislature which sought to extend the permission for autopsy beyond kin to a friend or person charged with burial.⁴⁵ Proponents felt that the law would simplify legal requirements for autopsy consent, save valuable medical time previously wasted in the search for remote and long-lost relatives, and promote medical knowledge by providing for a method of obtaining consent in cases of individuals dying without relatives.⁴⁶

All of these trends correlate with the policy that "autopsy, properly performed, remains one of the keystones of modern medicine. Simplification of the legal requirements for consent throughout the United States would be a definite step forward for medicine and would benefit society generally."⁴⁷

Summary

In summary, the basic arguments for the increased authorization both medically and medicolegally are:

1. It is the most accurate means of determining exact cause of death and often reveals unexpected findings.
2. Familial disease may be uncovered to the benefit of survivors.
3. Dependable vital statistics are important to humanity.

4. Medical knowledge and research are advanced.
5. Medical education of the hospital is advanced, thereby increasing local efficiency in the care of the sick.
6. Information of importance may be obtained in cases involving litigation.
7. Public safety is promoted by detection of unsuspected criminal acts.
8. Families derive comfort from the dispelling of uncertainty in deaths that are from clinically obscure causes.
9. Opposition to autopsy means opposition, though unwitting, to improving the health of human beings.
10. "Mortui vivos docent" (the dead teach the living). Thus the last gesture of the deceased is in the direction of aiding and cooperating with the living.⁴⁸

In the last analysis, when we combine all of the foreseeable medical and legal advantages for the extension of autopsy authorization, it is hard to argue to the contrary. If public policy underlies the basis for many legal criteria, as has been intimated in multitudes of decisions, the answers to the questions posed by this paper must inevitably be answered in the affirmative.

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Fasten Your Seat Belts, Please

IF EVERY well-known device to lessen the chances of serious injury in auto accidents had been used in each of the fatal automobile accidents in Indiana last year some 400 people who died in those accidents would now be alive.

Study by the Indiana State Police has shown that the recommended injury reducing adjuncts, (of which the seat belt is a typical and the most effective example), when used consistently, will reduce fatal and serious injury to moderate or slight injury in 43% of cases.

Similar studies have been conducted in other states, with uniform results. Injury-sparing devices will make a survivor out of a fatality four times out of 10.

Automotive Crash Injury Research originated in Indiana in 1953. Seat belts, safer steering wheels, padded dashes and better door locks were selected at an early date as injury-reducing accessories. Since then Cornell University has analyzed thousands of fatal auto accidents from this and many other states. Cars with the safety devices when matched against cars without them have demonstrated a reduction of injury potential up to between 40% and 50% time after time.

Recently Dr. Horace E. Campbell, Denver, in the *JAMA* recommended that seat belts be made stronger, with a minimal loop load of 5,000 pounds. This compares with the 8,000-pound belt used in military aircraft and the 4,000-pound standard of the Society of Automotive Engineers.

Dr. Campbell also stresses the need for a good energy-absorbing bumper for all cars. The longer the stopping distance the less the injury incurred. A bumper which would allow a stopping distance of two feet would reduce the crash forces to less than half what would be inflicted if a one-foot stopping distance was in effect.

Shoulder straps will more than double the effectiveness of seat belts. Dr. Campbell states that in a car with an efficient two-foot stopping distance a motorist with seat belt and shoulder straps could crash a bridge abutment at 40 miles per hour with little or no injury and at 60 miles per hour would still be within a survival level.

The Fort Wayne-Allen County Safety Seat Belt Program, an educational campaign which has been in effect for several months, has reported the generation of enough interest in seat

belts in Fort Wayne to create a shortage of belts in dealers' stocks.

All major automobile manufacturers, starting in 1962, will install safety seat belt anchors in the front seats of all passenger cars. This action will reduce the cost of belt installation considerably, and should increase the sale and use of them.

Legislation requiring installed seat belts in all new cars offered for sale has been suggested as

one way to increase seat belt usage. However, this is not the final answer. A driver or passenger must be convinced enough of the importance of the belt to insure that it will be fastened when the car is in motion. Compulsory installation of seat belts will not save lives if the belts are not used. A person who is convinced of their efficacy will be willing to spend a little money for belts, especially if the anchors are a part of the original equipment.

Cost of Medical Care

THE REAL COST of medical care is lower now than it was 20 years ago.

Measured in terms of a factory employee's hourly pay medical care can be obtained today for only 61% of what it cost in 1939, a decrease of 39%.

The AMA's recent report, based on data from the Bureau of Labor Statistics, shows that physicians' services required only 55% as much working time in 1959 as in 1939. Surgeons' services cost less than half the time. Optometric examinations and eyeglasses take only 42% of 1959 work time for the same services and goods that took 100% in 1939.

One cost item in medical care, hospital rates, requires more today than in 1939. However, when considered against the increased efficacy of hospital treatment with its more expensive but much more curative drugs, with its complex and expensive but more effective operations and with its shortened but more curative hospital stays, the increase in cost to 122% is actually a decrease in cost. A dollar spent in a hospital today buys more than it ever did before.

The Health Insurance Institute recently reported on statistics from the U. S. Department of Commerce relating to the cost of medical

care as related to total personal expenditures of all Americans. In 1959 5.8% of all disposable personal income went for medical care. Exactly the same proportion of income was spent for recreation. The total for recreation, alcohol and tobacco came to 11%.

Not only is our national medical bill reasonable when compared to the three items which may be thought of as being at least slightly non-essential. It has increased since 1939 by only 1.6% of total personal expenditures.

Medical care in 1939 absorbed 4.2% of personal spending; today the percentage is 5.8.

The good health of America is due to many factors: better medical care, better food, better housing, better working conditions. However, enough of the longevity, lowered mortality, better productivity and better all-around health is due to medical care as to make the increase in cost from 4.2% to 5.8% seem like the biggest bargain of all time.

Medical care is expensive. Everything that can be done should be done to make it less expensive and more efficacious. However it will always be expensive until the cost is measured in terms of what the nation realizes from it.

Medical care today is the biggest bargain of all time.

The Aged and the Actual Facts

SENATOR Clinton Anderson and others have been credited with originating and circulating the statement that the cost of an illness for an elderly patient is in the neighborhood of \$1000. This estimate is divided into \$450 hospital bill and \$550 physician's bill.

The Tarrant (Texas) County Medical So-

ciety investigated cost of care of older citizens in their county and reported actual facts. They found the cost of an average illness requiring hospitalization was \$449.13. Of this total \$384.51 was for the hospital bill and \$114.62 for the doctor.

Recently the Association of American Physi-

cians and Surgeons publicized the above statistics and added the report of the medical staff of the Renville County Hospital in Minnesota.

Actual figures for the year 1960 for hospitalized patients over 65 years of age in the Renville Hospital showed a total bill of \$456.23, with \$350.54 hospital charge and \$105.69 as the doctor bill.

Renville Hospital is a general hospital of 41 beds and 10 bassinets. In 1960 256 patients over age 65 counted for a total of 350 separate hospital admissions, 21.5% of the hospital's 1960 admissions. Surveys show that 75% of these patients paid their bills through private resources, 42% paying their entire bill themselves, and another 33% having partial or full assistance from their private insurance. The remainder, 25%, had their hospital bills paid by government agencies (62 paid by welfare boards, and two by Veterans Administration).

The medical staff report further states: Mem-

bers of our medical staff know of no individual in this area who is not receiving proper medical care because of financial inability to pay for such care.

The Renville County doctors "agree with the members of the Tarrant County Medical Society that 'Senator Anderson's figures are fantastic.'" Also "these data provide evidence that 75% of those patients over age 65 in our community are able to pay for their medical costs from private resources, and all the others are already adequately assisted by welfare agencies. There is no unmet need which requires the passage of new Federal legislation to pay for health care in our community."

Their final word is: "There is no warrant here to pass legislation which would compel the workers of America, through increased Social Security taxes, to pay the medical costs for the 75% of those over 65 who are already able to pay their own costs adequately."

Carcinoma of the Thyroid

AN OFFSHOOT of one article in the *JAMA* is worthy of comment. Astwood et al.¹ reported on the treatment of goiter and thyroid nodules with thyroid extract once again. This report was on 230 cases, in which they were able to reduce these simple goiters or nodular goiters in about two-thirds of the cases. One of their conclusions was that fear of carcinoma of the thyroid has little basis in fact. Following (or in some cases, preceding) mailing of this issue, the wire services picked up the article, and this was interpreted into headline form by *The Indianapolis Times*, as "Don't Take Goiter As Cancer Sign."

Certainly there are others who would agree with Astwood, but this appears to be oversimplification at its best. Many would disagree with Astwood. The figures for the incidence of

carcinoma of the thyroid ranging from perhaps four percent of multinodular goiters to 14-20% of solitary nodules belies this assumption. These figures have been cited by men such as Cattell in Boston, and Greene in London, and certainly Link,² writing in this *Journal*, has likened thyroid nodules with breast nodules as findings to be respected. Only time and further investigation will settle the issue, but we do not yet appear to be safe in viewing these conditions so calmly.

Jack W. Hickman, M.D.
Indianapolis

REFERENCES

1. Astwood, E. B., Cassidy, C. E., Aurbach, G. D.: Treatment of Goiter and Thyroid Nodules with Thyroid. *JAMA* 174:5, 459, Oct. 1, 1960.
2. Link, Goethe: Thyroid Malignancy. *Journal of Indiana State Medical Association* 53:680, April, 1960.

Editorial Notes . . .

Celebration of National Hospital Week in May was the occasion for a report by the Metropolitan Life Insurance Company Statistical Bulletin on the growth in hospital utilization. Between 1940 and 1959 the number

of patients admitted to hospitals in the United States rose from 10 million to 23.5 million. Only a small part of the increase was due to increased population—the admission rate rose from 76 to 133 per 1,000 population. One seg-

ment of the rise was due to the present-day popularity of the hospital for obstetrics. In 1940 less than 1 1/3 million babies were delivered in hospitals—there have been more than four million hospital births annually for the past several years. One big dividend: decrease in maternal mortality from 38 per 10,000 live births to three per 10,000.

The American Bakers Association is calling attention to the 20th anniversary of enrichment of flour and bread. Millers and bakers in 1941 accepted the recommendations of the Surgeon General, Dr. Thomas Parran, and his advisers, to add to white wheat flour the vital ingredients—thiamine, niacin, riboflavin and iron—which are removed in the milling process. At that time deficiency diseases due to the lack of the three vitamins and anemia due to lack of iron were prevalent. Today the vitamin deficiency states are a rarity. The Bakers Association will mail a booklet on this story to doctors who write to the association at 20 N. Wacker Drive, Chicago 6.

The Atomic Energy Commission and the University of California have announced the creation and identification of element 103. The name of Lawrencium has been suggested to honor Ernest O. Lawrence, inventor of the cyclotron and founder of the laboratory which discovered the new element. Almost three years' time was required to create the element in the heavy ion linear accelerator. Indication of its elusiveness and explanation of its absence in nature was evident when its half-life was measured and found to be eight seconds.

Medical care in Jamaica is reminiscent of the amiable alcoholic who drank only occasionally to relax himself—every once in a while he would get so relaxed he was stiff. Hospital care is so economically priced in Jamaica that everyone should be well cared for; the truth is that the system is so overloaded no one gets good care. Private hospital rooms cost less than \$2.00 a day, and hundreds of patients start standing in line at 6:30 a.m. each day to obtain free medical attention. The island has only 300 doctors, 180 of whom are in private practice. Population is 1,650,000. Medical care was mostly free in the old slave days;

now it is slowly developing into a system of private practice. Despite the shortages and difficulties, many of the tropical diseases such as yaws are now practically nonexistent, and better environmental medicine is being practiced.

The Journal was recently honored by compliments from the Evaluation and Awards Program of the International Council of Industrial Editors. The June, July and August issues for 1960 were entered in the contest with 669 other publications. *The Journal* improved its rating for "appearance" over that for 1959 and 1958, and scored almost as well for "content" and "writing," with an overall rating of 168.9 as compared with 170.2 in 1959. Specific comments were: "This is a polished, professional job—cover material is excellent, line drawings outstanding."

Since 1954 Lederle Medical Faculty Awards Program has allocated more than \$2 million to 120 faculty members in the United States and Canada. The purpose of the fund "is to assist able men and women to achieve their objective for full-time academic and research careers and to enable medical schools to develop promising clinical teachers and scholars." A recent follow-up showed that 110 of the recipients have remained in academic positions. Fifteen scholars will share \$250,000 this year. Julius J. Friedman, Ph.D., Assistant Professor of Physiology, Indiana University, was the recipient of a three-year award in 1960.

Prospects of passage of the Keogh bill are big this year. So says an authority on the subject—the originator and principal sponsor of the bill for many years, Rep. Eugene Keogh of New York. In the last session the bill was passed overwhelmingly by the house. It was approved by the Senate Finance Committee, but, due to a last-minute rush, was not voted on by the full Senate. Three members of the Senate Finance Committee, one of whom is Senator Vance Hartke, have introduced the legislation this year. It is possible that it will be law before this is published.

A hospital may be the best place in which to suffer accidental injury, but the practice is frowned upon and considerable care is exer-

cised to prevent such occurrences. The American Hospital Association announces the winners of its Hospital Safety Contest for 1960, based on the lowest number of injuries per number of man-hours worked. Awards are given to eight classes of hospitals according to the number of employees. The grand award winner in 1960 was the Veterans Administration Hospital in Northport, New York, with 2,743,213 man-hours without an injury.

Doctors are consulted for maternity care earlier, more often and more consistently now than ever before. A survey reported by Health Information Foundation shows that in 1958 as compared to 1953 expectant mothers saw their doctors earlier in pregnancy, consulted with them more regularly, entered hospitals for delivery more often and spent less time in the hospital per confinement. In 1958 total private expenditures on maternity services were estimated at \$1,150,000,000—and this does not count the money value of free maternity services. The average expenditure for hospital, physicians' and similar services was \$272.

Stairway fire doors which can't protect lives because they are blocked open by wooden wedges are serious and common hazards in schools and other public buildings. Heat-sensitive controls now in use will close doors and prevent the spread of actual fire, but do not act soon enough to prevent the spread of smoke which is the principal killer. The National Fire Protection Association is considering a recommendation that door controls be connected to the automatic sprinkler system or to an automatic fire alarm. The association is planning a revised code of fire safety for hospitals and nursing homes. All measures are designed to provide maximum safety at minimum reasonable expense. The revised code will be important in the construction of new housing units for the aged.

Seven out of 10 workers covered under group health insurance policies issued during

1960 have the right to retain their health insurance protection when they retire. The Health Insurance Institute notes that there is an aggressive trend toward such coverage. In 1956 about 45% of new group insurance beneficiaries were favored with post-retirement benefits, and in 1959 the estimate was 55%.

The AMA Legislative Roundup announces that Representative John Bell Williams, a Democrat from Mississippi, placed in the Congressional Record a resolution by the board of the Methodist Church of Clinton, Mississippi, in which it withdrew all financial support from the National Council of Churches. The Board objected to the fact that the National Council of Churches had "supported proposals for a system of socialized medicine being sought in H.R. 4222 (King-Anderson bill)."

Ceremonies at Spencer on April 3 broke ground for the construction of a new Community Medical Center. The Center is being built under the auspices and guidance of the Sears-Roebuck Foundation and is financed by contributions of Spencer citizens.

Capsule report on traffic injuries from the safety booklet issued annually by The Travelers Insurance Companies (circulation 3.3 million): Over 80% of all personal injury accidents involved driving violations. Deaths last year increased by one per cent over 1959 to 38,000. Nonfatal injuries increased seven per cent to 3,078,000. Pedestrian casualties were up five per cent to 263,100. More than 1,000,000 casualties were attributed to speeding; 40% of the deaths occurred on weekends. More than 95% of the vehicles involved were in apparently good condition. Drivers of ages between 18 and 25 had a little better record than formerly but still accounted for almost 28% of all fatal accidents—twice what their numbers would warrant. The safety record of commercial vehicles is much better than that of private passenger cars. ◀

President's Page

A FUNDAMENTAL TRUISM

"Man . . . cannot be economically free . . . if he is enslaved politically; conversely, man's political freedom is illusory if he is dependent for his economic needs on the state."

—Senator Barry M. Goldwater.

The above self-evident fact expresses, in language we all can understand, the ideal we strive for in preserving the free practice of medicine. Attainment of that ideal is becoming more and more difficult by the hour, and indeed, before this is published, the Fabian socialists may have concocted a new method for exploiting their program.

On this page last month a warning was sounded that the process of "log-rolling" might be applied to members of both the House Ways and Means Committee (where legislative proposals for Social Security medicine are now locked up) and the Senate Finance Committee (where amendments to Social Security legislation already passed by the House may be considered).

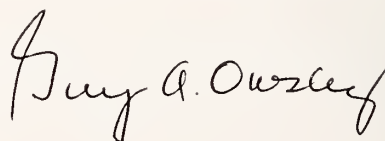
Today that prognosis has proved accurate. The chief executive, already recognized as an astute politician, has outdone all of his "new deal" and "fair deal" predecessors by FIRST asking for the approval of an additional 70-odd new federal judgeships, each to be filled by appointees of his choice. One would be naive indeed if he didn't recognize at once that many of these appointments will go to those "obstructionists" who presently occupy important posts in the National Congress and the events of recent weeks bear out this assumption.

It is common knowledge that the Chairman of the House Ways and Means Committee has been offered one of these plums; a life-time appointment with all of the appurtenances thereto.

This brings us to the realization that the sacrifice of principle in mortal man is inversely proportional to his desire for self-preservation. This is the fundamental truism.

If this appointment is accepted by the present Chairman of the Ways and Means Committee the mantle will fall upon the sponsor of the current proposal for Social Security medicine, Congressman King of California. Anyone familiar with the power of a committee chairman under such circumstances, would be fuzzy in his thinking if he didn't recognize that the King-Anderson bill could be blasted out at once (and this may have happened before this page is published).

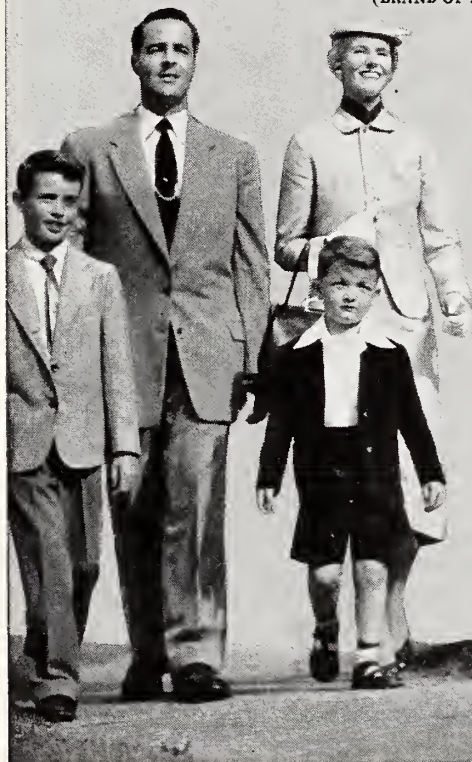
If this be the case we are then confronted with a vote by the Congress and if present indications are accurate we will have the most God-awful job cut out for us we have as yet faced. Brace yourself for the possibility and IF we are fortunate enough to win, give credit to the few who are doing so much for so many, because our own battalions are scattered worse than an 8-gauge goose gun.



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REPORTS TO ISMA



The House of Delegates in South Bend was a success and will, I'm sure, go on record as having accomplished a great deal. A fine new set of Bylaws was substituted for the old ones. The fireworks were dazzling when the section regarding the raise in dues was discussed, and when the new budget was considered. But the end result was, I believe, in the best interests of the Auxiliary.

The dues were raised one dollar. This additional money will enable the Auxiliary to become a more businesslike operation. It will enable us to determine what the Auxiliary's financial needs really are.

This will illustrate what I mean. In the past, a chairman who has spent something like \$55 is likely to think it is not worthwhile to apply for the meagre \$5.00 that the budget allows her. Since she doesn't apply for it and state what she actually has spent, it is impossible to make an accurate appraisal of that chairmanship's financial needs. Now, with a more generous secretarial allowance and a new travel fund, she will be more inclined to apply for reimbursement.

You will be interested to know that a suggestion was made to consider having our House of Delegates at the same time as the ISMA General Assembly in October. This will be brought up at the House of Delegates in Elkhart next April.

I don't have to be entirely serious in this article, because you will be able to read of the Auxiliary's accomplishments in 1960/1961 in a subsequent *Journal*. Therefore, I can tell you of some of the LESS important things that happened at the convention.

At the banquet, one of the young ladies on the convention committee was anxious to sell the decorations—beautiful handmade rose trees. Mrs. Owsley said, "Go ask father to buy me one. He is carrying my money because my wallet doesn't fit this purse. But tell him to use his own money."

Instead of approaching Dr. Owsley at the head table, the young lady went up to a guest who sat near him and said, "Mrs. Owsley says you have her money, and you're to buy her a rose tree. But she wants you to use your own money."

The guest was Father Murphy who gave the invocation!

One delightfully bright spot of the convention was caused by a slip of the tongue. Our presiding officer, in announcing a prize drawing open only to those who arrived punctually at the business session, inadvertently referred to it as the "Early Door Bird Prize."

Unfortunately, she is never guilty of trite remarks. Otherwise she might have continued, "Remember, girls, the early door catches the bird."

Epi Kentner

'Personalized Medicine' and You*

The elderly citizens in your community and firm will have the best possible assurance of longer, healthier and more useful lives if they take advantage of "personalized medicine." By "personalized medicine," we mean the present system based largely on freedom of choice.

And what are the advantages of "personalized medicine" over other systems? The Chamber believes there are many. Just consider its attributes even now.

These would include closer, far more special attention to the health of the individual than the government could decree; the preservation of the family doctor patient-physician relationship; faster service, with less waiting for treatment; higher standards of medical care; and more incentives for private research to obtain even better medicines and techniques.

The Chamber believes that "personalized medicine" is so good that it's worth crusading for. It recently issued a statement to that effect, pointing out that Americans have the best health care of any large nation on earth, with every expectation of continued improvement.

To help strengthen this medical care system, the Chamber has urged businessmen to extend their employees' group health programs to cover retired workers. It also has suggested that states review the problems of their aging to see if they need to set up programs to provide health care for those in low income brackets under the law passed by the last Congress.

Despite its obvious benefits, there are some who would scuttle "personalized medicine" in favor of a compulsory program financed by higher Social Security taxes on you and your employees. The Chamber will point out the dangers of such a change when federal legislation to that effect is considered by Congress.

In its statement, the Chamber warned that such a move might necessitate raising Social Security taxes to a point where the people might find the tax costs of the whole Social Security system to be too burdensome.

If you would like more information on the subject of medical care, further data can be obtained without charge from the Chamber's Economic Security Program. ◀

* Reprinted with permission from the Jan. 27, 1961, issue of *Washington Report*, a publication of the Chamber of Commerce of the United States.

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Meadows Shopping Center
1 E. Washington Street
1820 E. 10th Street
1300 E. 86th Street
Rockville Road & Lyndhurst Drive
Southgate Shopping Center
609 W. 11th Street
2105 N. Arlington
3802 College Avenue
5061 East 38th Street
3-5 E. 38th Street
6287 College Avenue
Speedway Shopping Center
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ANDERSON

609-109 By Pass

BEDFORD

908 16th Street
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June 1961

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Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of paid-up members of the Indiana State Medical Association as of May 1, 1961.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1019 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

Name	City	County	Name	City	County
A					
Aagesen, Walter J.	Anderson	Madison	Allen, Donald R.	Indianapolis	Marion
Abell, Charles F.	Marion	Grant	Allen, Hubert E. (S)	Richmond	Wayne-Union
Able, Walter	Columbus	Bartholomew-Brown	Allen, L. Howard	Bedford	Lawrence
Abramson, Allan L.	Gary	Lake	Allen, Orris T. (S)	Terre Haute	Vigo
Abreu, Benedict E.	Indianapolis	Marion	Allen, Robert K.	Indianapolis	Marion
Acher, Robert P.	Greensburg	Decatur	Allen, Robert T.	Richmond	Wayne-Union
Acker, Robert B. (S)	South Bend	St. Joseph	Almquist, Carl O.	Gary	Lake
Acre, Robert R.	Evansville	Vanderburgh	Altier, William H.	Fowler	Benton
Adair, Samuel	Jeffersonville	Clark	Alvarez, Paul	Gary	Lake
Adair, William K. (S)	Crothersville	Jackson	Alvey, Charles R.	Muncie	Delaware-Blackford
Adams, Daniel S. (S)	Ft. Myers, Fla.	Marion	Alvis, Edmond O.	Indianapolis	Marion
Adams, Julia L.	Muncie	Delaware-Blackford	Alward, John H.	Kokomo	Howard
Adams, E. Wade	Fort Wayne	Allen	Ambrose, Jesse C.	Noblesville	Hamilton
Adams, Max R.	Flora	Carroll	Ambrozaitis, Kazys	Gary	Lake
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Adamski, Michael S.	Logansport	Cass	Amini, Sohrab	Huntingburg	Dubois
Addleman, Robert H.	Indianapolis	Marion	Amos, Robert L.	New Castle	Henry
Ade, Charles H.	Lafayette	Tippecanoe	Amstutz, Henry C.	Goshen	Elkhart
Ade, Mary Keller	Lafayette	Tippecanoe	Amy, William E. (S)	Corydon	Harrison-Crawford
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Adler, David L.	Columbus	Bartholomew-Brown	Anderson, John B.	Vincennes	Knox
Adler, Raymond N.	Evansville	Vanderburgh	Anderson, John T.	Indianapolis	Marion
Adney, Frank B.	Richmond	Wayne-Union	Anderson, Milton H.	Evansville	Vanderburgh
Advincula, Luis	Pendleton	Madison	Anderson, Richard M.	Vincennes	Knox
Adye, Wallace M.	Evansville	Vanderburgh	Anderson, Walter C.	Terre Haute	Vigo
Agana, Adriano A.	Gary	Lake	Anderson, Wendell C.	Indianapolis	Marion
Ahlbrand, Roland C.	Fort Wayne	Allen	Andrews, Hugh K.	Franklin	Johnson
Aiken, Arthur F.	Fort Wayne	Allen	Angel, Virgil E.	Whiting	Lake
Aiken, Milo M.	Plainfield	Hendricks	Angeles, Uldarico A.	Gary	Lake
Aiken, Nevin E.	Fort Wayne	Allen	Ansbacher, Stefan (H)	Marion	Grant
Ake, Loren	Richmond	Wayne-Union	Anshutz, William M.	Indianapolis	Marion
Akre, Philip R.	Indianapolis	Marion	Antes, Earl H.	Evansville	Vanderburgh
Albertson, Frank P.	Indianapolis	Marion	Antreasian, Berj	Indianapolis	Marion
Alcorn, Merritt O.	Madison	Jefferson-Switzerland	Appel, Richard H.	Indianapolis	Marion
Alderfer, Henry	Marion	Grant	Apple, Eddie R.	Salem	Washington
Aldred, Allen W.	Lawrenceburg	Dearborn-Ohio	Applegate, Albert E.	Frankfort	Clinton
Aldrich, Harry D.	Indianapolis	Marion	Arata, Justin E.	Fort Wayne	Allen
Aldrich, Howard	Indianapolis	Marion	Arata, Lucian A.	Shelbyville	Shelby
Alexander, Ezra D.	Indianapolis	Marion	Arbeiter, Herbert I.	Munster	Lake
Alexander, John E.	Evansville	Vanderburgh	Arbogast, John L.	Indianapolis	Marion
Alexander, Stephen J.	Crawfordsville	Montgomery	Arbogast, Paul B.	Vincennes	Knox
Alfano, Paul A.	Gary	Lake	Arbuckle, William E. (S)	Indianapolis	Marion
Alford, James A.	Hamilton	Steuben	Arendell, Robert E.	Evansville	Vanderburgh
Allegretti, Michael L.	Hammond	Lake	Arford, John E.	Warsaw	Kosciusko
			Arisman, Ralph K.	South Bend	St. Joseph
			Arlook, Theodore D.	Elkhart	Elkhart
			Armalavage, Leon J.	Gary	Lake
			Armer, Robert M.	Indianapolis	Marion
			Armington, Charles L.	Anderson	Madison
			Armington, Robert L.	Anderson	Madison
			Armstead, John W.	Indianapolis	Marion

Name	City	County	Name	City	County
Armstrong, Thomas D.	Michigan City	La Porte	Ballenger, William E.	Richmond	Wayne-Union
Arney, Amos	Michigan City	La Porte	Balsbaugh, George	North	
Arnold, Aaron L.	Indianapolis	Marion		Manchester	Wabash
Arnold, Robert D.	Indianapolis	Marion	Baltes, Joseph H.	Fort Wayne	Allen
Aronson, Sidney S.	Indianapolis	Marion	Banister, Revel H. (S)	Indianapolis	Marion
Arrowsmith, James L.	Munster	Lake	Bankoff, Milton L.	Michigan City	La Porte
Arthur, Nora M. (S)	Washington	Daviess-Martin	Banks, Horace M. (S)	Indianapolis	Marion
			Bannon, William G.	Terre Haute	Vigo
Artis, Myrle E.	Kokomo	Howard	Baptisti, Arthur, Jr.	Indianapolis	Marion
Artz, Richard W.	Angola	Steuben	Baran, Charles	South Bend	St. Joseph
Ash, Harold H.	W. Lafayette	Tippecanoe	Barch, John W.	Fort Wayne	Allen
Asher, Ernest O. (S)	New Augusta	Marion	Barclay, Irvin C.	Evansville	Vanderburgh
Asher, James W.	New Augusta	Marion	Bard, Frank B.	Crothersville	Jackson
Atchison, Kenneth C. (S)	Rockport	Spencer	Barden, Tom P.	Indianapolis	Marion
Atienza, Rizalino T.	Gary	Lake	Barnes, Helen B.	Greenwood	Johnson
Atkins, Clarence C.	Rushville	Rush	Barnett, Ralph E.	Peru	Miami
Atwood, William H.	Elkhart	Elkhart	Barnhart, Willard T.	Evansville	Vanderburgh
Ault, Carl H.	Kokomo	Howard	Barone, Carmelo V.	Mishawaka	St. Joseph
Ault, Roy	Terre Haute	Vigo	Barrett, Robert V.	Indianapolis	Marion
Aust, Charles H.	Indianapolis	Marion	Barrett, Thomas L.	Vincennes	Knox
Austin, Charles E.	Anderson	Madison	Barron, Elmer A.	East Chicago	Lake
Austin, Eugene W.	Evansville	Vanderburgh	Barrow, John H.	Dale	Spencer
Austin, Maynard A. (S)	Evansville	Vanderburgh	Barry, Maurice J. (S)	Indianapolis	Marion
Austin, Richard P.	Bedford	Lawrence	Bartholomew, Mary L.	Goshen	Elkhart
Avery, George O.	Indianapolis	Marion	Bartle, James Leo	Indianapolis	Marion
Ayres, Wendell W.	Marion	Grant	Bartlett, Donald T.	Vincennes	Knox
			Bartley, Max D.	Indianapolis	Marion
			Barton, David M.	Indianapolis	Marion
			Barton, Reginald R.	Gary	Lake
			Barton, Robert	Angola	Steuben
			Barton, Willoughby M.	Centerville	Wayne-Union
			Bartsch, Harvey L.	South Bend	St. Joseph
			Bash, Wallace E.	Fort Wayne	Allen
			Baskett, Russell J.	Jonesboro	Grant
			Bassett, Margaret	Thorntown	Boone
			Bassler, Carl R. (S)	Niles, Mich.	St. Joseph
			Basso, Rudolph V.	Richmond	Wayne-Union
			Bastnagel, William F.	Indianapolis	Marion
			Batman, Gordon W.	Indianapolis	Marion
			Batt, David J.	Muncie	Delaware-Blackford
			Battersby, J. Stanley	Indianapolis	Marion
			Batties, Paul A.	Indianapolis	Marion
			Bauer, Thomas B.	Indianapolis	Marion
			Baughn, William L.	Anderson	Madison
			Baum, John R.	Warsaw	Kosciusko
			Baumeister, Herbert E.	Indianapolis	Marion
			Baumgartner, Jeraldine	Fort Wayne	Allen
			Baxter, Harry R.	Seymour	Jackson
			Baxter, John P.	Indianapolis	Marion
			Baxter, Neal E.	Bloomington	Owen-Monroe
			Baxter, Samuel M.	New Albany	Floyd
			Bayley, William E.	Lafayette	Tippecanoe
			Baylor, Edward M.	Evansville	Vanderburgh
			Baynes, Frank L.	Wolcott	White
			Beach, Robert R.	Indianapolis	Marion
			Beamer, Parker R.	Indianapolis	Marion
			Beams, Ralph H.	Fort Wayne	Allen
			Bean, Joseph S.	Logansport	Cass
			Beardsley, Frank A.	Frankfort	Clinton
			Beaven, John B.	Jasper	Dubois
			Beaver, Ernest R.	Rensselaer	Jasper-Newton
			Beaver, Howard W.	Indianapolis	Marion
			Beaver, Norman E.	Berne	Adams
			Bechtold, Samuel E.	South Bend	St. Joseph
			Beck, David C.	Monticello	White
			Beck, Evart M.	Indianapolis	Marion
			Beck, Herma A. (S)	Lebanon	Boone
			Beck, Robert E.	Evansville	Vanderburgh
			Beck, Thomas A.	Swayzee	Grant
			Becker, Harry G.	Indianapolis	Marion
			Becker, Philip H.	Crown Point	Lake
			Becker, Samuel W.	Whiting	Lake
			Beckes, Ellsworth W.	Vincennes	Knox
			Beconovich, Robert	Hammond	Lake

B

Babb, Forrest J.	Stockwell	Tippecanoe
Bacevich, Andrew J.	East Chicago	Lake
Bachmann, Arnold J.	Indianapolis	Marion
Backer, George P.	LaPorte	LaPorte
Backer, Henry G.	Ferdinand	Dubois
Backer, Mary B.	LaPorte	LaPorte
Backs, Alton J.	South Bend	St. Joseph
Badders, Ara C. (S)	Portland	Jay
Badenhausen, Walter E., Jr.	Indianapolis	Marion
Bahler, Dean R.	W. Lafayette	Tippecanoe
Bahr, Robert E.	Fort Wayne	Allen
Bailey, Douglas A.	Marion	Grant
Bailey, Earl W.	Logansport	Cass
Bailey, Edwin B.	Linton	Greene
Bailey, Lawrence S.	Zionsville	Boone
Bailey, Paul P.	Fort Wayne	Allen
Baird, Melvin S.	Indianapolis	Marion
Bakemeier, Otto H.	Indianapolis	Marion
Bakemeier, Robert E.	Indianapolis	Marion
Baker, Avey M.	New Albany	Floyd
Baker, Eldon E.	Delphi	Carroll
Baker, Guy D. (S)	Crandall	Harrison-Crawford
Baker, Herman M. (S)	Evansville	Vanderburgh
Baker, John R.	Lafayette	Tippecanoe
Baker, Leslie M.	Aurora	Dearborn-Ohio
Baker, Mason R.	Evansville	Vanderburgh
Baker, Milan D.	Culver	Marshall
Baker, Warren	Michigan City	La Porte
Bakos, Edward R.	Hammond	Lake
Balaguer, Carmen	Hammond	Lake
Balch, James F.	Indianapolis	Marion
Balcom, Francis H.	New Castle	Henry
Baldrige, William O.	Terre Haute	Vigo
Baldwin, John H. (S)	Jeffersonville	Clark
Balingit, Benjamin L.	East Chicago	Lake
Balkema, Catherine M.	Lafayette	Tippecanoe
Ball, Clay A. (S)	Muncie	Delaware-Blackford
Ball, John R.	Fort Wayne	Allen
Ball, Joseph E.	Indianapolis	Marion
Ball, Margaret J.	Fort Wayne	Allen
Ball, Phillip	Muncie	Delaware-Blackford
Ballard, Charles A. (S)	Logansport	Cass

Name	City	County	Name	City	County
Bedwell, Marion H.	Sullivan	Sullivan	Bishop, Harry A.	Frankton	Madison
Beebe, Milton O. Jr.	Versailles	Ripley	Bishop, Robert E.	Bluffton	Wells
Beeler, Franklin K.	Anderson	Madison	Bissonnette, Roger P.	Evansville	Vanderburgh
Beeler, John W.	Indianapolis	Marion	Bivin, James H.	Mooreville	Morgan
Beeler, Raymond C. (S)	Indianapolis	Marion	Bixler, Donald P.	Anderson	Madison
Beeson, Wilbur P.	Greenfield	Hancock	Bixler, James A.	Berne	Adams
Begley, Joseph W., Jr.	Evansville	Vanderburgh	Bixler, Louis C.	South Bend	St. Joseph
Beggs, Lowell F.	Columbus	Bartholomew-Brown	Bizer, Mier	Jeffersonville	Clark
Behn, Walter M., Jr.	Kokomo	Howard	Bjorklund, C. Ray	Hobart	Lake
Behn, Walter M.	Gary	Lake	Black, Boyd K.	Vincennes	Knox
Behnke, Roy H.	Indianapolis	Marion	Black, Edgar K.	Circleville, O.	Wabash
Beierlein, Karl M.	Fort Wayne	Allen	Black, Henry R.	Indianapolis	Marion
Beilke, Clifford A.	East Chicago	Lake	Black, M. James	Brownsburg	Hendricks
Belding, Ray T.	Kokomo	Howard	Black, Joe M.	Seymour	Jackson
Bell, Horace D.	South Bend	St. Joseph	Blackburn, Erwin	South Bend	St. Joseph
Belshaw, George	Indianapolis	Marion	Blackford, Florence	Indianapolis	Marion
Belt, James H.	Indianapolis	Marion	Blackford, Ralph E.	Indianapolis	Marion
Benages, Anthony G.	Terre Haute	Vigo	Blackwell, Donald S.	Indianapolis	Marion
Benchik, Frank A.	East Chicago	Lake	Blake, Albert L.	Indianapolis	Marion
Bender, Martin J.	Evansville	Vanderburgh	Blassaras, Chris	Anderson	Madison
Bender, Robert L.	Elkhart	Elkhart	Blatt, A. Ebner	Indianapolis	Marion
Bendler, Carl H.	Gary	Lake	Blazey, Arthur G.	Washington	Daviess-Martin
Benedict, Charles D.	LaGrange	LaGrange	Bledsoe, James G.	New Castle	Henry
Benedict, Paul F.	Indianapolis	Marion	Blessinger, Louis H.	Corydon	Harrison-Crawford
Benham, Lawrence E.	Bedford	Lawrence	Blessinger, Paul J.	Jasper	Dubois
Benken, Lawrence D.	Muncie	Delaware-Blackford	Blichert, Peter A.	Fort Wayne	Allen
Bennett, Abner P.	Evansville	Vanderburgh	Blix, Fred M.	Ladoga	Montgomery
Bennett, Ivan F.	Indianapolis	Marion	Bloemker, Edward F.	Indianapolis	Marion
Bennett, J. B.	Warren	Huntington	Bloom, Asa W.	Marion	Grant
Bennett, Jene R.	South Bend	St. Joseph	Bloom, George R.	Elkhart	Elkhart
Benson, James E.	Elkhart	Elkhart	Bloomer, Richard S.	Rockville	Parke-Vermillion
Benz, Jesse (S)	Marengo	Harrison-Crawford	Blosser, Blaine A. (S)	Fremont	Steuben
Benz, Owen F.	Wanatah	La Porte	Blosser, Howard V. (S)	Fort Wayne	Allen
Bergal, Milton B.	Gary	Lake	Blossom, Paul W.	Richmond	Wayne-Union
Bergan, Joseph A.	Michigan City	La Porte	Blum, Leon L.	Terre Haute	Vigo
Bergendahl, Emil H.	Fort Wayne	Allen	Boardman, Carl (S)	Gary	Lake
Berger, Morley	Beech Grove	Marion	Boaz, William D.	Wabash	Wabash
Berghoff, James R.	Fort Wayne	Allen	Bobb, Kenneth E.	Seymour	Jackson
Berghoff, Raymond J.	Fort Wayne	Allen	Bobowski, Stan J.	San Francisco, Calif.	Marion
Bergwall, Warren L.	Muncie	Delaware-Blackford	Bodnar, Leslie M.	South Bend	St. Joseph
Berke, Robert D.	South Bend	St. Joseph	Bogan, William C.	South Bend	St. Joseph
Berkshire, Shaffer B.	North Vernon	Jennings	Bogardus, Carl R.	Austin	Scott
Berkson, Myron E.	Michigan City	La Porte	Boggs, Eugene F.	Indianapolis	Marion
Berman, Edward J.	Indianapolis	Marion	Bogmenko, Leon T.	Pendleton	Madison
Berman, Jacob K.	Indianapolis	Marion	Bohner, Caryle B.	Hidalgo, Mexico	Marion
Bernard, Marvin R.	Gary	Lake	Bolin, John T. (S)	Mountain Home, Arkansas	Lake
Bernoske, Daniel G.	Crown Point	Lake	Bolin, Robert C.	Lafayette	Tippecanoe
Best, Robert C.	Whiting	Lake	Boling, Frederick F.	Indianapolis	Marion
Bethea, Dennis A. (S)	Hammond	Lake	Boling, Grover C., Jr.	Indianapolis	Marion
Bethea, Robert O.	Farmersburg	Sullivan	Boling, Richard	Elkhart	Elkhart
Beutler, Theodore V.	Fort Wayne	Allen	Bolman, Ralph M.	Fort Wayne	Allen
Beverland, Malon E. (S)	Indianapolis	Marion	Bomalaski, Martin D.	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph	Bombar, Leslie E.	Hammond	Lake
Bibler, Henry E.	Muncie	Delaware-Blackford	Bonaventura, Angelo P.	East Chicago	Lake
Bibler, Lester D.	Indianapolis	Marion	Bond, George S. (S)	Indianapolis	Marion
Bichacoff, Billie D.	Ukiah, Calif.	Allen	Bond, Virginia	Indianapolis	Marion
Bickel, David A.	South Bend	St. Joseph	Bond, Walter C.	Clay City	Clay
Bidney, Evelyn B.	Bloomington	Owen-Monroe	Bond, William H.	Indianapolis	Marion
Biggs, William W.	Columbus	Bartholomew-Brown	Bonsett, Charles A.	Indianapolis	Marion
Bigler, Frederick W.	Goshen	Elkhart	Booher, Norman R.	Indianapolis	Marion
Bill, Robert O.	Indianapolis	Marion	Booher, Olga Bonke	Indianapolis	Marion
Billings, Elmer R.	Elkhart	Elkhart	Booker, Harold E.	Indianapolis	Marion
Bills, R. James	Gary	Lake	Boone, Max L.	Peru	Miami
Bills, Robert N.	Gary	Lake	Boone, Robert D.	Evansville	Vanderburgh
Bird, Charles R. (S)	Indianapolis	Marion	Boonstra, Charles E.	Bluffton	Wells
Birdzell, John P.	Crown Point	Lake	Booth, Boynton H.	Indianapolis	Marion
Birmingham, Peter J. (S)	South Bend	St. Joseph	Booth, Franklin M.	South Bend	St. Joseph
Birum, Patricia	Union City	Randolph	Booze, James	Indianapolis	Marion
Bisgyer, Jay L.	Gary	Lake	Bopp, Henry, Jr.	Terre Haute	Vigo

Name	City	County	Name	City	County
Bopp, James	Terre Haute	Vigo	Brillhart, James R.	Indianapolis	Marion
Borak, Walter J.	Gary	Lake	Brincko, John	Gary	Lake
Boren, Paul R.	Poseyville	Posey	Bringas, Irineo B.	Gary	Lake
Bornstein, Herschel	Gary	Lake	Brink, Calvin C. (S)	Gary	Lake
Borland, Raymond M.	Bloomington	Owen-Monroe	Bristol, Henry M. S.	Detroit, Mich.	Vigo
Borough, Lester D.	South Bend	St. Joseph	Britt, Robert	Evansville	Vanderburgh
Bosch, Ralph	Seymour	Jackson	Britton, Welbon D.	Montezuma	Parke-Vermillion
Bosler, Howard A.	Waterford Mills, mail Goshen	Elkhart	Brock, Earl E. (S)	Anderson	Madison
Bossard, John W.	Fort Wayne	Allen	Brock, Joseph T.	New Castle	Henry
Boswell, Robert W. C.	Evansville	Vanderburgh	Brockman, Wilfred	Corydon	Harrison-Crawford
Botkin, Charles (S)	Muncie	Delaware-Blackford	Brockmole, Arnold W.	Evansville	Vanderburgh
Botkin, Clyde G.	Muncie	Delaware-Blackford	Brodie, Donald W.	Indianapolis	Marion
Botkin, Thomas	Muncie	Delaware-Blackford	Bromley, Luman W.	Fort Wayne	Allen
Boughman, Joseph D.	Kokomo	Howard	Bronson, Paul J.	Terre Haute	Vigo
Bowdoin, George E.	Elkhart	Elkhart	Brooks, Fred R., Jr.	Indianapolis	Marion
Bowen, Otis R.	Bremen	Marshall	Brooks, G. Tanner	Richmond	Wayne-Union
Bowers, Charles R.	Anderson	Madison	Broomes, Edward L. C.	East Chicago	Lake
Bowers, Copeland C.	Kokomo	Howard	Brose, Paul E.	Indianapolis	Marion
Bowers, Gah T.	Fort Wayne	Allen	Broshears, Kenneth P.	Linton	Greene
Bowers, Garvey B.	Kokomo	Howard	Brosius, Robert H. W.	Fort Wayne	Allen
Bowers, George W.	Indianapolis	Marion	Brown, Archie E.	Indianapolis	Marion
Bowers, John A.	Indianapolis	Marion	Brown, David B.	Gary	Lake
Bowers, John A.	Kokomo	Howard	Brown, David E.	Indianapolis	Marion
Bowers, Jesse W. (S)	Fort Wayne	Allen	Brown, Dewitt W.	Indianapolis	Marion
Bowman, Charles M.	Albion	Noble	Brown, Earl R., Jr.	Kokomo	Howard
Bowman, Geo. W. (S)	Indianapolis	Marion	Brown, Frances T.	Indianapolis	Marion
Bowser, Philip G.	Goshen	Elkhart	Brown, Frank M.	Indianapolis	Marion
Boyd, Charles S.	East Chicago	Lake	Brown, Frederic W.	Fort Wayne	Allen
Boyd, H. Clark	Terre Haute	Vigo	Brown, George E.	Greenwood	Johnson
Boyd, Stella N.	Evansville	Vanderburgh	Brown, George W.	Evansville	Vanderburgh
Boyer, Floyd A.	Indianapolis	Marion	Brown, Gordon T.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant	Brown, James C.	Valparaiso	Porter
Boyle, Carroll L.	Poseyville	Posey	Brown, Jesse F.	Gary	Lake
Boys, Frank F.	East Chicago	Lake	Brown, John S.	Carlisle	Sullivan
Boze, Robert L.	Berne	Adams	Brown, Kenneth H.	New Albany	Floyd
Bradley, Charles F.	Hobart	Lake	Brown, Leland G.	Muncie	Delaware-Blackford
Bradley, Louis F.	Bluffton	Wells	Brown, Leo R.	Gary	Lake
Bradley, Stephen C. (S)	Terre Haute	Vigo	Brown, Marcel S.	Spencer	Owen-Monroe
Brady, Kingdon	Morocco	Jasper-Newton	Brown, Richard J.	Richmond	Wayne-Union
Brady, Samuel G.	Gary	Lake	Brown, Robert L.	Evansville	Vanderburgh
Brady, Thomas A.	Indianapolis	Marion	Brown, Robert M.	Marion	Grant
Brakel, Frank J.	Evansville	Vanderburgh	Brown, Robert R.	Terre Haute	Vigo
Brandman, Harry	Gary	Lake	Brown, Stewart D.	Albany	Delaware-Blackford
Brandt, William E.	Fort Wayne	Allen	Brown, Thomas C.	Indianapolis	Marion
Brauchla, Carl H. (S)	Anderson	Madison	Brown, Thomas M.	Muncie	Delaware-Blackford
Brauer, Abraham A.	East Chicago	Lake	Brown, Wendell E.	Indianapolis	Marion
Braun, Benjamin D.	Chicago, Ill.	Lake	Browning, James S.	Indianapolis	Marion
Braunlin, Robert F.	Marion	Grant	Browning, William M.	Indianapolis	Marion
Brayton, John R., Jr.	Key West, Fla.	Marion	Brownley, Emma J.	Indianapolis	Marion
Brayton, John R.	Indianapolis	Marion	Brubaker, Harold S.	Huntington	Huntington
Brayton, Lee	Indianapolis	Marion	Bruce, Reginald A.	Indianapolis	Marion
Brazelton, Osborne T. (S)	San Diego, Calif.	Gibson	Brueckman, F. Robert	Indianapolis	Marion
Brecht, Harvey J.	South Bend	St. Joseph	Bruegge, Theodore J.	Kokomo	Howard
Breneman, William L.	Lowry AFB, Denver, Colo.	Marion	Bruetsch, Walter L.	Indianapolis	Marion
Brenner, Howard B.	Hammond	Lake	Bruner, Ralph W. (S)	Jeffersonville	Clark
Bretz, John M.	Huntingburg	Dubois	Bryan, Franklin A.	Fort Wayne	Allen
Brickley, Harry D.	Indianapolis	Marion	Bryan, Robert E.	Kendallville	Noble
Brickley, Richard A.	Indianapolis	Marion	Bryan, Stanton L.	Evansville	Vanderburgh
Bridges, Alvin	Anderson	Madison	Bryant, Edward G.	East Chicago	Lake
Bridges, William L.	Fort Wayne	Allen	Buchanan, Wallace D.	South Bend	St. Joseph
Bridwell, Edgar	Bedford	Lawrence	Buche, Franklin P. (S)	Richmond	Wayne-Union
Briggs, Robert W.	Indianapolis	Marion	Buchholz, Ransom R.	McKinney, Texas	Vanderburgh
			Buckingham, Richard E.	Bloomington	Owen-Monroe
			Buckles, David L.	Anderson	Madison
			Buchman, Marshall H.	New Albany	Floyd
			Buckner, George D.	Fort Wayne	Allen
			Buckner, Joy F.	Bluffton	Wells
			Buechler, William F.	Elwood	Madison

Name	City	County	Name	City	County
Buechner, Frederick W.	South Bend	St. Joseph	Cameron, Don F.	Angola	Steuben
Buehler, George M.	Jeffersonville	Clark	Cameron, Mary H.	Angola	Steuben
Buehner, Donald F.	Evansville	Vanderburgh	Campagna, Ettore A.	East Chicago	Lake
Buell, Forrest R.	Clay City	Clay	Campbell, H. Edwin, Jr.	Indianapolis	Marion
Bugh, Charles W.	Fairbanks, Alaska	Marion	Campbell, John A.	Indianapolis	Marion
Buhrmester, Harry C.	Lafayette	Tippecanoe	Campbell, Patrick B.	Elkhart	Elkhart
Bullard, Mattie J.	Gary	Lake	Campbell, Robert L.	Indianapolis	Marion
Bullers, Robert C.	Franklin	Johnson	Campbell, Sam W.	Noblesville	Hamilton
Bullington, George E.	Franklin	Johnson	Campbell, William T.	Bedford	Lawrence
Bunker, Ladoska Z.	North Manchester	Wabash	Canaday, James W. (S)	Indianapolis	Marion
Burcham, James B.	Gary	Lake	Canganelli, Vincent G.	Lafayette	Tippecanoe
Burdette, Harold F.	Indianapolis	Marion	Cannon, Daniel H.	New Albany	Floyd
Burger, Robert A.	Gary	Lake	Cantwell, Edgar R.	Vincennes	Knox
Burger, Thomas C.	Evansville	Vanderburgh	Capestany, Max A.	Indianapolis	Marion
Burghard, Rolla D.	Indianapolis	Marion	Caplin, Irvin	Indianapolis	Marion
Burk, James M.	Decatur	Adams	Caplin, Samuel S.	Indianapolis	Marion
Burket, Cecil R.	Bremen	Marshall	Carberry, George A.	Gary	Lake
Burkhardt, Boyd A.	Tipton	Tipton	Carbone, Joseph A.	Gary	Lake
Burkle, John C. (S)	Lafayette	Tippecanoe	Carey, J. Albert	Gary	Lake
Burkle, Robert J.	Indianapolis	Marion	Carey, Willis W. (S)	Kendallville	Noble
Burks, Jess E.	Crawfordsville	Montgomery	Carlberg, Dale K.	Jeffersonville	Clark
Burman, Leonard	Los Angeles, Calif.	Marion	Carlo, Ernest R.	Fort Wayne	Allen
Burnett, Arthur B.	New Castle	Henry	Carlson, Edward A. (S)	Peru	Miami
Burnett, Paul C.	Logansport	Cass	Carlson, Milton R.	Indianapolis	Marion
Burnikel, Ray H.	Evansville	Vanderburgh	Carlson, Norman R.	Michigan City	La Porte
Burns, John T.	Lafayette	Tippecanoe	Carlson, Ralph F.	Evansville	Vanderburgh
Burns, Paul E.	Montpelier	Delaware- Blackford	Carlyle, Ivan E. (S)	Michigantown	Clinton
Burress, Clyde R.	Evansville	Vanderburgh	Carmody, Raymond F.	Gary	Lake
Burris, Floyd L.	Michigan City	La Porte	Carneal, Thomas E. (S)	Winamac	Pulaski
Burton, Philip B.	Fort Bragg, N. C.	Marion	Carney, Joel T.	Jeffersonville	Clark
Burwell, Stanley W.	Muncie	Delaware- Blackford	Carney, John C.	Monticello	White
Bush, Charles E.	Kirklin	Clinton	Carpenter, Bennie	Griffith	Lake
Bush, Hargis R.	Cannelton	Perry	Carpenter, James B.	Lafayette	Tippecanoe
Bush, Jack A.	Lafayette	Tippecanoe	Carpenter, Ramesh S.	Garrett	DeKalb
Buslee, Roger M.	South Bend	St. Joseph	Carpentier, Harry F.	Princeton	Gibson
Bussard, Clifford F. (S)	South Bend	St. Joseph	Carpentier, James R.	La Porte	La Porte
Bussard, Frank W.	South Bend	St. Joseph	Carr, Joseph H.	Henryville	Clark
Butler, Joe B.	Crothersville	Jackson	Carrel, Francis E.	Frankfort	Clinton
Butler, John O.	Indianapolis	Marion	Carroll, Bertha Rose	W. Lafayette	Tippecanoe
Butler, Robert M.	Indianapolis	Marion	Carroll, John C.	Decatur	Adams
Butterfield, Robert M.	Muncie	Delaware- Blackford	Carroll, Mary E.	Crown Point	Lake
Butts, Milton A.	South Bend	St. Joseph	Carson, Wayne	Indianapolis	Marion
Butz, Ralph O.	Muncie	Delaware- Blackford	Carter, F. R. Nicholas	South Bend	St. Joseph
Byrd, Ryland P.	Jeffersonville	Clark	Carter, Fred S.	La Porte	La Porte
Byrn, Howard W. (S)	New Albany	Floyd	Carter, James E.	Indianapolis	Marion
Byrne, Louis E.	Roachdale	Putnam	Carter, Jean V.	Tipton	Tipton
Byrne, Robert J.	Bicknell	Knox	Carter, John O.	Hobart	Lake
C			Carter, Oren E.	Indianapolis	Marion
Cacia, John J.	Evansville	Vanderburgh	Carter, Robert E., Jr.	Noblesville	Hamilton
Cagle, Bob R.	New Palestine	Hancock	Carter, William D.	Walkerton	St. Joseph
Cahn, Hugo M.	Indianapolis	Marion	Cartwright, Emor L. (S)	Fort Wayne	Allen
Cahué, Antonio R.	Gary	Lake	Cartwright, Jack D.	La Porte	La Porte
Cain, David R.	New Castle	Henry	Casey, Stanley M.	Huntington	Huntington
CaJacob, Melville E.	Terre Haute	Vigo	Cassady, James V.	South Bend	St. Joseph
Caldwell, Marilyn R.	Indianapolis	Marion	Cassady, John R.	South Bend	St. Joseph
Caldwell, Milton V.	Terre Haute	Vigo	Cattell, Lee M.	Kokomo	Howard
Caldwell, William C. (S)	Evansville	Vanderburgh	Cavins, Alexander W.	Terre Haute	Vigo
Call, Earle B. (S)	Knightstown	Henry	Caylor, Charles H.	Bluffton	Wells
Call, Herbert F.	Indianapolis	Marion	Caylor, Harold D.	Bluffton	Wells
Call, William H.	Ann Arbor, Mich.	Marion	Caylor, Truman E.	Bluffton	Wells
Callaghan, Winship C.	Greensburg	Decatur	Chael, Thomas C.	Hammond	Lake
Calli, Louis	North Vernon	Jennings	Challman, William B.	Mt. Vernon	Posey
Calvert, John H., Jr.	Indianapolis	Marion	Chambers, Alan R.	Fort Wayne	Allen
Calvert, Raymond R.	Lafayette	Tippecanoe	Chambers, Carol R.	Union City	Randolph
Calvin, Helen M.	North Liberty	St. Joseph	Chambers, Leroy B.	Union City	Randolph
Calvin, O. Walter	North Liberty	St. Joseph	Chambers, Pauline D.	Greenwood	Johnson
			Chamblee, Roland W.	South Bend	St. Joseph
			Chandler, Leon H.	Goshen	Elkhart
			Chappel, Alfred T.	Franklin	Johnson
			Charles, Henry L.	Hagerstown	Wayne-Union
			Chase, James A.	Fort Wayne	Allen
			Chattin, Herbert O.	Vincennes	Knox
			Chattin, Robert E.	Loogootee	Daviess- Martin
			Chattin, William R.	Indianapolis	Marion
			Chattin, Vance J.	Washington	Daviess- Martin

Name	City	County	Name	City	County
Chen, Ko K.	Indianapolis	Marion	Collins, Robert C.	Indianapolis	Marion
Cheng, Sylvia F.	Logansport	Cass	Colosey, Frederick J.	South Bend	St. Joseph
Cheydleur, Eleanor P.	Evansville	Vanderburgh	Colvin, Robert C.	Newburgh	Warrick
Chernish, Stanley M.	Indianapolis	Marion	Combs, Herman T.	Evansville	Vanderburgh
Chevalier, Robert A.	Indianapolis	Marion	Combs, John H.	Evansville	Vanderburgh
Chidlaw, Benj. W. (S)	Hammond	Lake	Combs, Loyal W.	W. Lafayette	Tippecanoe
Childress, Richard H.	Indianapolis	Marion	Combs, Pearl B. (S)	Evansville	Vanderburgh
Childress, Robert C.	Gainesville, Fla.	Marion	Combs, Stuart R.	Terre Haute	Vigo
Childs, Wallace E.	Madison	Jefferson-Switzerland	Comeau, William J.	Marion	Grant
Chivington, Paul V.	Indianapolis	Marion	Compton, George L.	Tipton	Tipton
Christiansen, Philip A.	Indianapolis	Marion	Compton, Walter A.	Elkhart	Elkhart
Christie, Marvin	Beech Grove	Marion	Conforti, Victor P.	Terre Haute	Vigo
Christie, Robert W.	Muncie	Delaware-Blackford	Congleton, G. C. (S)	Terre Haute	Vigo
Christophel, Verna	Mishawaka	St. Joseph	Conklin, James O.	Terre Haute	Vigo
Chroniak, Walter	Indianapolis	Marion	Conklin, Raymond L.	South Bend	St. Joseph
Chu, Johnson C. S.	Logansport	Cass	Conley, John E.	Fort Wayne	Allen
Chube, David D.	Gary	Lake	Conley, Joseph L. (S)	Indianapolis	Marion
Chun, Wallace H.	Madison	Jefferson-Switzerland	Conley, Thomas M.	Kokomo	Howard
Clancy, James F.	Hammond	Lake	Connell, Paul S.	Plymouth	Marshall
Clark, Cecil P.	Indianapolis	Marion	Connell, Victor O.	Bourbon	Marshall
Clark, George A.	Indianapolis	Marion	Connelly, Richard D.	Fort Wayne	Allen
Clark, Ivan A.	Paoli	Orange	Connerley, Marion L.	Terre Haute	Vigo
Clark, Jack P.	Syracuse	Kosciusko	Connoy, Andrew F.	Westfield	Hamilton
Clark, Joseph	Huntington	Huntington	Connoy, Leo F.	Westfield	Hamilton
Clark, Lawson J.	Indianapolis	Marion	Conrad, Henry W.	Lawrenceburg	Dearborn-Ohio
Clark, Marion E.	Cambridge City	Wayne-Union	Constan, Evan	Westville	La Porte
Clark, Stanley A. (S)	South Bend	St. Joseph	Conway, Chester C.	Indianapolis	Marion
Clark, Thomas W.	Evansville	Vanderburgh	Conway, Glenn	Indianapolis	Marion
Clark, William B., Jr.	Jeffersonville	Clark	Conway, Thomas J.	Terre Haute	Vigo
Clark, William H.	South Bend	St. Joseph	Cook, Charles E.	North Manchester	Wabash
Clark, William R.	Fort Wayne	Allen	Cook, Gordon C.	South Bend	St. Joseph
Clarke, Elton R.	Kokomo	Howard	Cook, Robert G.	Bluffton	Wells
Clarkson, Clarence G.	Liberty	Wayne-Union	Cooksey, Thomas L. (S)	Santa Barbara, Calif.	Montgomery
Classen, Pete R. C.	Elkhart	Elkhart	Cooney, Charles J.	Fort Wayne	Allen
Clay, Eleanor	Columbus	Bartholomew-Brown	Coons, John D.	Lebanon	Boone
Claybourn, Norman L.	East Chicago	Lake	Coons, Ritchie	Lebanon	Boone
Cleveland, John B.	Michigan City	La Porte	Cooper, B. Trent	Roanoke	Huntington
Clevenger, Joseph H.	Muncie	Delaware-Blackford	Cooper, Harry L. (S)	South Bend	St. Joseph
Clevinger, William G.	Indianapolis	Marion	Cooper, John	Muncie	Delaware-Blackford
Cline, Kenneth L.	Wyatt	St. Joseph	Cooper, Leo K.	Gary	Lake
Close, Gerald A.	S. Darenth Kent, England	Marion	Cooper, Waller W.	Evansville	Vanderburgh
Close, W. Donald	Indianapolis	Marion	Cope, Stanton E.	Huntington	Huntington
Clouse, Paul A.	Evansville	Vanderburgh	Corcoran, Patrick J. V.	Evansville	Vanderburgh
Clunie, William A.	Huntington	Huntington	Cormican, Herbert L.	Elkhart	Elkhart
Coade, George E.	Long Beach, Calif.	Marion	Cornacchione, Matthew	Indianapolis	Marion
Coates, Jacqueline	Indianapolis	Marion	Cornell, Robert A.	Crawfordsville	Montgomery
Cobb, Clarence M.	Logansport	Cass	Corpe, Kenneth F.	Rushville	Rush
Coble, Frank H.	Richmond	Wayne-Union	Corrao, Gaetano	Gary	Lake
Cochran, Harry A., Jr.	Fort Wayne	Allen	Corsentino, Bart E.	Vincennes	Knox
Cochran, John F.	Bloomington	Owen-Monroe	Cortese, James V.	Indianapolis	Marion
Cochran, Robert B.	Muncie	Delaware-Blackford	Cortese, Thomas A.	Indianapolis	Marion
Cockrum, William M.	Evansville	Vanderburgh	Costello, Albert J.	Hammond	Lake
Coddens, Avery L.	Earl Park	Benton	Costin, Robert L.	Indianapolis	Marion
Coddington, Robert C.	Indianapolis	Marion	Cotter, Edward R.	Hammond	Lake
Coffel, Melvin H.	Vincennes	Knox	Cottrell, Robert F.	Fort Wayne	Allen
Coggeshall, Warren E.	Indianapolis	Marion	Couch, Rex D.	Indianapolis	Marion
Cohen, Hyman	Hebron	Porter	Coughenour, J. Robert	Indianapolis	Marion
Cohen, Irving	Plainfield	Hendricks	Countryman, Frank W.	Indianapolis	Marion
Cohn, Alvin F.	Indianapolis	Marion	Coursey, James O.	Plymouth	Marshall
Cole, Ira	Lafayette	Tippecanoe	Covalt, Wendell E.	Muncie	Delaware-Blackford
Cole, William L.	Evansville	Vanderburgh	Covell, Harry M.	Auburn	DeKalb
Coleman, Floyd B.	Waterloo	DeKalb	Covey, Thomas J.	Valparaiso	Porter
Coleman, Henry G.	Salem	Washington	Cox, Clifford E. (S)	Indianapolis	Marion
Coleman, Joseph E.	Evansville	Vanderburgh	Cox, Leon T.	Richmond	Wayne-Union
Colip, George D.	South Bend	St. Joseph	Coyner, Alfred B.	Lafayette	Tippecanoe
Collins, Hubert L.	Indianapolis	Marion	Craft, Kenneth L.	Indianapolis	Marion
Collins, Jack T.	Bluffton	Wells	Craig, Alexander F.	New Castle	Henry
			Craig, Reuben	Kokomo	Howard
			Craig, Reuben A.	Kokomo	Howard
			Craig, Richard M.	Fort Wayne	Allen
			Craig, Robert A.	Syracuse	Kosciusko
			Crain, James W.	Williamsport	Fountain-Warren

Name	City	County	Name	City	County
Crampton, Chas. C. (S)	Delphi	Carroll	Daves, William L.	Evansville	Vanderburgh
Crandall, Lathan A.	Elkhart	Elkhart	Davidoff, Manuel A.	Fort Wayne	Allen
Crawford, James H.	Evansville	Vanderburgh	Davidson, Dale A.	Indianapolis	Marion
Crawford, John A.	Indianapolis	Marion	Davidson, Harold H.	Evansville	Vanderburgh
Crawford, Theodore R.	Kokomo	Howard	Davidson, N. Cort	Indianapolis	Marion
Creek, Jean A.	Bloomington	Owen-Monroe	Davies, Robert	New Castle	Henry
Cregger, Irby E.	Indianapolis	Marion	Davis, Alice Hall (S)	Hammond	Lake
Crevello, Albert J.	Evansville	Vanderburgh	Davis, Bennie L.	Indianapolis	Marion
Crimm, Paul D.	Evansville	Vanderburgh	Davis, Carl M.	Valparaiso	Porter
Cring, George V. (S)	Portland	Jay	Davis, Claude E.	Angola	Steuben
Cripe, Earl P.	Bremen	Marshall	Davis, Edgar C. (S)	Muncie	Delaware- Blackford
Cripe, Jerome H.	Indianapolis	Marion	Davis, Edward A.	South Bend	St. Joseph
Cripe, William	Portland	Jay	Davis, Howard B.	Lafayette	Tippecanoe
Crist, John R.	Mt. Vernon	Posey	Davis, John A.	Flat Rock	Shelby
Crockett, Franklin S. (H)	West Lafayette	Tippecanoe	Davis, John A.	Indianapolis	Marion
Crockett, Wayne A.	Terre Haute	Vigo	Davis, John C. (S)	Logansport	Cass
Cron, William J.	Warsaw	Kosciusko	Davis, Joseph B.	Marion	Grant
Cronin, H. Joseph	Portland	Jay	Davis, Lloyd H. (S)	Madison	Jefferson- Switzerland
Cross, David G.	Indianapolis	Marion	Davis, Margaret M.	Indianapolis	Marion
Crowder, James H.	Sullivan	Sullivan	Davis, Marvin R.	Columbus	Bartholomew- Brown
Crowley, Joseph B.	South Bend	St. Joseph	Davis, Merrill S. (S)	Marion	Grant
Crudden, Charles H.	Evansville	Vanderburgh	Davis, Neal	Gary	Lake
Crum, Marion M.	Angola	Steuben	Davis, Parvin M.	New Albany	Floyd
Cuff, Steve C.	Evansville	Vanderburgh	Davis, Richard M.	Marion	Grant
Culbertson, Carl S.	South Bend	St. Joseph	Davis, Sam J.	Indianapolis	Marion
Culbertson, Clyde G.	Indianapolis	Marion	Davis, Thomas N. III	Hammond	Lake
Cullen, Paul K.	Indianapolis	Marion	Davis, William H.	New Market	Montgomery
Cullen, Paul K., Jr.	Rochester, Minn.	Marion	Deal, Eleanor H.	Speedway City	Marion
Cullane, Chris W.	Evansville	Vanderburgh	Dean, Donald I.	Rushville	Rush
Culloden, William G.	Indianapolis	Marion	Dearmin, Robert M.	Indianapolis	Marion
Culp, John E.	Fort Wayne	Allen	DeArmond, Murray	Indianapolis	Marion
Cunningham, Gene C.	Indianapolis	Marion	De Bois, Elon	Gary	Lake
Cunningham, Robert D.	Marion	Grant	Deems, Myers B.	Evansville	Vanderburgh
Cure, Charles W.	Indianapolis	Marion	Deever, John W.	Indianapolis	Marion
Cure, Elmer T.	Muncie	Delaware- Blackford	DeFries, John J.	New Paris	Elkhart
Currie, Robert W.	Indianapolis	Marion	DeGrazia, Eugene J.	Valparaiso	Porter
Curry, R. Louis	Indianapolis	Marion	Deitch, Robert D.	Indianapolis	Marion
Curtner, Myron L. (S)	Vincennes	Knox	DeMotte, C. Bowen	Indianapolis	Marion
Custer, Edward W.	South Bend	St. Joseph	DeNaut, James F.	Knox	Starke
Cuthbert, Marvin P.	Indianapolis	Marion	Denham, Robert H.	South Bend	St. Joseph
Cutshaw, James A.	Monroeville	Allen	Dennison, Alfred D., Jr.	Indianapolis	Marion
Cymbala, Bohdan	Evansville	Vanderburgh	Denny, E. Rankin	Terre Haute	Vigo
Czenkusch, Helen G.	Indianapolis	Marion	Denny, Forrest L.	Indianapolis	Marion
D			Denny, James W.	Indianapolis	Marion
Daggy, Benjamin T.	Richmond	Wayne-Union	Denny, Melvin H.	Rushville	Rush
Daggy, James R.	Richmond	Wayne-Union	Denton, Larkin D.	Greentown	Howard
Dahling, Clemens W.	New Haven	Allen	Denzer, Edward K.	Evansville	Vanderburg
Dailey, James E.	Watseka, Ill.	Marion	Denzer, William O.	Evansville	Vanderburgh
Dainko, Alfred J.	East Chicago	Lake	Deppe, Charles F.	Franklin	Johnson
Dale, Maxwell H.	Connersville	Fayette- Franklin	DeRenne, William L.	Newport	Parke- Vermillion
Daley, Edward H.	Indianapolis	Marion	Derhammer, George L.	Brookston	White
Dallas, Fred R.	Indianapolis	Marion	DesJean, Paul A.	Indianapolis	Marion
Dallas, Mary E.	Indianapolis	Marion	Dester, Herbert E.	Greencastle	Putnam
Dalton, William W.	Indianapolis	Marion	DeTar, George B. (S)	Winslow	Pike
Dalton, Wilson L.	Shelbyville	Shelby	Detrick, Herbert W. (S)	Sarasota, Fla.	Lake
Daly, Joseph M.	Indianapolis	Marion	Dettloff, Frederick	Greencastle	Putnam
Daniel, John C.	Indianapolis	Marion	Deur, Julius	Lafayette	Tippecanoe
Daniel, Robert A.	Gary	Lake	Deutsch, William	Muncie	Delaware- Blackford
Danieleski, Ladislaus J.	Gary	Lake	DeVoe, Kenneth	South Bend	St. Joseph
Daniels, George R. (S)	Marion	Grant	DeWees, Dwight L.	Indianapolis	Marion
Dann, Morton W.	Indianapolis	Marion	DeWester, Gerald M.	Indianapolis	Marion
Dannacher, William D.	Wabash	Wabash	Dhein, Donald T.	Crown Point	Lake
Dare, Lee A.	Jeffersonville	Clark	Dian, August J.	Gary	Lake
Darling, Dorothy	Gary	Lake	Dickerson, W. Martin	Monticello	White
Datzman, Basil J.	La Porte	La Porte	Dickey, William M.	Bay Pines, Fla.	Marion
Datzman, Richard C.	Fort Wayne	Allen	Dickson, Carolyn L.	Indianapolis	Marion
Daugherty, Forest D.	Columbus	Bartholomew- Brown	Dickson, Dale D.	Greensburg	Decatur
Daugherty, Fred N.	Crawfordsville	Montgomery	Dieckman, Herbert S.	Evansville	Vanderburgh
Daugherty, William L.	Hutsonville, Ill.	Sullivan	Diefendorf, Charles F. (S)	Evansville	Vanderburgh

Name	City	County	Name	City	County
Dielman, Franklin C. (S)	Fulton	Fulton	Duemling, Arnold H.	Fort Wayne	Allen
Dierdorf, Fred W.	APO 125, New York, N.Y.	Marion	Dugan, Thomas	Columbus	Bartholomew- Brown
Dierolf, Edward J.	Gary	Lake	Dukes, Betty	Dugger	Sullivan
Dieter, William J.	Westville	La Porte	Dukes, David A.	Tell City	Perry
Dietl, Ernest L.	South Bend	St. Joseph	Dukes, David J.	Corydon	Harrison- Crawford
Dill, Charles W.	Beech Grove	Marion	Dukes, Frederic M. (S)	Dugger	Sullivan
Dill, Myron K.	Indianapolis	Marion	Dukes, Joe E.	Dugger	Sullivan
Dillman, Carl E.	Corydon	Harrison- Crawford	Dulin, Basil B.	Anderson	Madison
Dilts, Robert L.	Indianapolis	Marion	Dunbar, Fred E.	Marion	Grant
Dimmett, Robert P.	Metairie, La.	Warrick	Duncan, John S.	Gary	Lake
Dingle, Paul E.	Richmond	Wayne-Union	Duncan, Raymond	Bedford	Lawrence
Dingley, Albert F.	South Bend	St. Joseph	Duncan, Stuart J.	Indianapolis	Marion
Dininger, William S.	Winchester	Randolph	Duncan, William A.	Indianapolis	Marion
Dintaman, Paul G.	Indianapolis	Marion	Dunham, Henry H.	Evansville	Vanderburgh
Dirks, Kenneth R.	A.P.O., New York, N. Y.	Marion	Dunlap, D. Logan	South Bend	St. Joseph
Dittmer, Jack E.	Valparaiso	Porter	Dunn, Ferrell W. (S)	Muncie	Delaware- Blackford
Dittmer, Thomas L.	Valparaiso	Porter	Dunning, Thomas W.	Muncie	Delaware- Blackford
Ditton, Irvin W. (S)	Fort Wayne	Allen	Dunstone, Harry C.	Fort Wayne	Allen
Dixon, Fritz R.	Winston- Salem, N. C.	Marion	Dupes, Lowell E.	Indianapolis	Marion
Dixon, Rex W.	Anderson	Madison	Dupler, Lee F. W.	Indianapolis	Marion
D'Luzansky, James J.	Indianapolis	Marion	Durham, Lowell J.	La Porte	La Porte
Dodd, Robert D.	South Bend	St. Joseph	Durkee, Melvin S.	Evansville	Vanderburgh
Dodd, Roberts K.	Evansville	Vanderburgh	Durkin, John W., Jr.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware- Blackford	Dusard, Joseph C.	Bedford	Lawrence
Dodds, Wemple	Crawfordsville	Montgomery	DuSold, Donald D.	Crown Point	Lake
Doenges, James L.	Anderson	Madison	Dutchess, C. Toney	Galveston	Cass
Doherty, Raymond J.	Crown Point	Lake	Dyar, Edwin W.	Indianapolis	Marion
Dolezal, Bernard J.	South Bend	St. Joseph	Dycus, Walter A.	Evansville	Vanderburgh
Dome, Hardin S. (S)	Tell City	Perry	Dye, William E.	Oakland City	Gibson
Donahue, Claude M.	Carmel	Hamilton	Dyer, George W.	Terre Haute	Vigo
Donahue, Francis E.	Dublin	Wayne-Union	Dyer, Wallace K.	Evansville	Vanderburgh
Donahue, George R.	Lafayette	Tippecanoe	Dyke, Richard W.	Indianapolis	Marion
Donahue, James M.	Indianapolis	Marion	Dyken, Mark L.	New Castle	Henry
Donaldson, Frank C.	Anderson	Madison	Dykhuizen, Theodore A.	Frankfort	Clinton
Donato, Albert M.	Indianapolis	Marion	Dzenitis, Andriers J.	Indianapolis	Marion
Donchess, Joseph C.	Gary	Lake	Eades, R. Charles	South Bend	St. Joseph
Doneff, Ronald H.	Indianapolis	Marion	Eades, Ralph C.	Valparaiso	Porter
Donnelly, Everett F.	South Bend	St. Joseph	Earl, Max M.	Kokomo	Howard
Doran, J. Hal	Indianapolis	Marion	Earnhart, Harold H.	Edinburg	Johnson
Dorman, Willis L.	Indianapolis	Marion	Earp, Evanston B.	Indianapolis	Marion
Dormire, Robert D.	Warsaw	Kosciusko	Easter, James N.	Butler	Jennings
Dorrance, Thomas O.	Bluffton	Wells	Eastman, Joseph R., Jr.	Indianapolis	Marion
Dosado, Elpidio B.	Gary	Lake	Eaton, Edwin R.	Indianapolis	Marion
Doss, Jerome F.	Indianapolis	Marion	Eaton, Lyman D.	Indianapolis	Marion
Doty, James R., Jr.	Indianapolis	Marion	Eaton, Marion J.	Lafayette	Tippecanoe
Doughty, Samuel R., Jr.	Indianapolis	Marion	Ebbinghouse, Tom	Richmond	Wayne-Union
Dovey, Edward G.	Elkhart	Elkhart	Ebert, J. Wayne	Indianapolis	Marion
Dowd, Joseph A.	Indianapolis	Marion	Eberwein, John H. (S)	Indianapolis	Marion
Dowell, Emil H.	Rockville	Parke- Vermillion	Ebin, Judah L.	South Bend	St. Joseph
Downer, Luther H.	Evansville	Vanderburgh	Eby, Ida L. (S)	Warren	Huntington
Drake, Dale W.	Evansville	Vanderburgh	Echeverria, Rodolfo E.	Elkhart	Elkhart
Drake, James R.	Anderson	Madison	Echsner, Herman J.	Columbus	Bartholomew- Brown
Drake, John C.	Anderson	Madison	Eckerle, John E.	New Albany	Floyd
Drake, Marion C.	Elwood	Madison	Eckert, Russell A.	Logansport	Cass
Draper, Merlin H. (S)	St. Peters- burg, Fla.	Allen	Edmonds, Kendrick	Bedford	Lawrence
Drennen, Robert V.	Anderson	Madison	Edwards, Bernard E.	South Bend	St. Joseph
Drew, Arthur L., Jr.	Indianapolis	Marion	Edwards, Edward T., Jr.	Vincennes	Knox
Dreyer, Ralph W.	Richmond	Wayne-Union	Edwards, Henry G.	Terre Haute	Vigo
Drummy, William W.	Terre Haute	Vigo	Edwards, William F.	New Albany	Floyd
Dryden, Gale E.	Indianapolis	Marion	Egan, Sherman	South Bend	St. Joseph
Dublin, Madeline P.	Francesville	Pulaski	Egbert, Herbert L.	Indianapolis	Marion
DuBois, Charles C. (S)	Warsaw	Kosciusko	Eggers, Ernest L. (S)	Hammond	Lake
DuBois, Ramon B.	Lafayette	Tippecanoe	Eggers, Henry W.	Hammond	Lake
Dudgeon, Charles A.	Hartford City	Delaware- Blackford	Eggers, Richard	Crawfordsville	Montgomery
			Egnatz, Charles D.	Munster	Lake
			Egnatz, Nicholas	Hammond	Lake
			Ehrich, William S. (S)	Pawley's Island, S. C.	Vanderburgh

Name	City	County	Name	City	County
Eicher, Palmer O.	Indianapolis	Marion	Fair, Herbert D. (S)	Muncie	Delaware-Blackford
Eikenberry, Hugh W.	Indianapolis	Marion	Faith, Ira L.	Evansville	Vanderburgh
Eisaman, Jack L.	Bluffton	Wells	Fargher, Francis M.	Michigan City	La Porte
Eisenberg, David A.	Martinsville	Morgan	Fargher, Robert A.	La Porte	La Porte
Eisterhold, John A.	Evansville	Vanderburgh	Farner, James E.	Mishawaka	St. Joseph
Eldridge, Gail E.	Indianapolis	Marion	Farnsworth, Samuel A.	La Porte	La Porte
Elkins, James P.	Indianapolis	Marion	Farquhar, John S., Jr.	Fort Wayne	Allen
Elledge, Ray	Hammond	Lake	Farr, James C.	Paragon	Morgan
Elleman, John H.	Edinburg	Johnson	Farrell, John J., Jr.	Greenfield	Hancock
Ellett, John, Jr.	Coatesville	Hendricks	Farrell, Joseph T.	Indianapolis	Marion
Elliott, John C. (S)	Guilford	Dearborn-Ohio	Farris, John J.	Washington	Daviess-Martin
Elliott, Paul W.	Lafayette	Tippecanoe	Faul, Henry J.	Evansville	Vanderburgh
Elliott, Ralph A.	Gary	Lake	Faulkner, Donald J.	Hobart	Lake
Elliott, Thomas A.	Elkhart	Elkhart	Fausset, C. Basil	Indianapolis	Marion
Ellis, Davis W.	Rushville	Rush	Faust, Howard M. Jr.	Anderson	Madison
Ellis, F. D.	North Vernon	Jennings	Faw, Melvin L.	Evansville	Vanderburgh
Ellis, George M.	Connersville	Fayette-Franklin	Feferman, Martin E.	South Bend	St. Joseph
Ellis, Lyman H.	Lizton	Hendricks	Feinn, Harry S.	La Porte	La Porte
Ellis, Seth W.	Anderson	Madison	Feldman, Max	South Bend	St. Joseph
Ellis, William N.	Indianapolis	Marion	Feldner, Ronald P.	Lansing, Ill.	Lake
Ellison, Alfred	La Jolla, Calif.	St. Joseph	Fell, Robert M.	Rosedale	Parke-Vermillion
Elshout, Clem H.	La Porte	La Porte	Fenneman, Robert J.	Evansville	Vanderburgh
Elsten, Aubrey W.	Anderson	Madison	Ferguson, Arthur N.	Fort Wayne	Allen
Elston, Lynn W.	Fort Wayne	Allen	Ferguson, Donald H.	Anderson	Madison
Elston, Ralph W.	Fort Wayne	Allen	Ferguson, William B.	Lafayette	Tippecanoe
Elward, Carl J.	Wabash	Wabash	Ferrara, Donald W.	Peru	Miami
Emenhiser, Donald C.	New Haven	Allen	Ferrara, Joseph F.	Franklin	Johnson
Emenhiser, John L.	Fort Wayne	Allen	Ferrara, Samuel J.	Peru	Miami
Emery, Charles B.	Bedford	Lawrence	Ferrell, Mars B.	Fortville	Hancock
Emhardt, John T.	Indianapolis	Marion	Ferry, Francis A.	Indianapolis	Marion
Emhardt, John W. A. (S)	Indianapolis	Marion	Ferry, John L.	Whiting	Lake
Emme, Richard W.	Harlan	Allen	Ferry, Paul W.	Kokomo	Howard
Endicott, Wayne H.	Greenfield	Hancock	Fessler, Gordon S.	Rising Sun	Dearborn-Ohio
Engel, Edward L.	Evansville	Vanderburgh	Fey, Charles W.	Bedford	Lawrence
Engel, Howard R.	South Bend	St. Joseph	Fichman, Abraham M.	Fort Wayne	Allen
Engeler, James E.	Lafayette	Tippecanoe	Fickas, Dallas	Evansville	Vanderburgh
Engle, Russell B.	Winchester	Randolph	Fiederlein, Frederick J.	Indianapolis	Marion
Engleman, Harry K. (S)	Georgetown	Floyd	Fiedler, Howard W.	Indianapolis	Marion
English, Hubert M.	Gary	Lake	Fields, Donald C.	Lafayette	Tippecanoe
English, John P.	South Bend	St. Joseph	Fields, Donald L.	Kokomo	Howard
Ensminger, Leonard A. (S)	Indianapolis	Marion	Filipek, Walter J.	South Bend	St. Joseph
Entner, Charles L.	Dunkirk	Jay	Finfrock, James D.	Elkhart	Elkhart
Episcopo, Arsenius R.	Salem	Washington	Finneran, Joseph C.	Indianapolis	Marion
Erdel, Milton W.	Frankfort	Clinton	Fipp, August L.	Rome City	Noble
Erehart, Mark G.	Huntington	Huntington	Firestein, Ben Z.	South Bend	St. Joseph
Ericksen, Lester G.	South Bend	St. Joseph	Firestein, Ray	South Bend	St. Joseph
Erickson, Gustaf W.	South Bend	St. Joseph	Fisch, Charles	Indianapolis	Marion
Ericson, Harold L.	Windfall	Tipton	Fischer, A. Alan	Indianapolis	Marion
Ericson, Homer S.	Indianapolis	Marion	Fischer, Burnell	Hammond	Lake
Erwin, W. Robert	La Porte	La Porte	Fischer, Carlton N.	La Porte	La Porte
Eshelman, Henry R.	Monterey	Pulaski	Fischer, Warren E.	Anderson	Madison
Eskew, Kenneth W.	Sullivan	Sullivan	Fish, Clyde M. (S)	Edwardsburg, Mich.	St. Joseph
Espino, Jose C.	Munster	Lake	Fish, Edson C.	South Bend	St. Joseph
Espy, Theodore R.	Gary	Lake	Fisher, Frank C.	Indianapolis	Marion
Estes, Ambrose C.	Bloomington	Owen-Monroe	Fisher, Frank L.	Crawfordsville	Montgomery
Evans, Frederick H.	Indianapolis	Marion	Fisher, Gerald E.	Ippy French Equatorial Africa	Marion
Evans, Frederick J.	Clinton	Parke-Vermillion	Fisher, Henry	Marion	Grant
Evans, Paul V.	Indianapolis	Marion	Fisher, John E.	Attica	Fountain-Warren
Everly, Ralph V.	Indianapolis	Marion	Fisher, John E.	Newcastle	Henry
Eversman, George H., Jr.	Terre Haute	Vigo	Fisher, Lawrence F. (S)	South Bend	St. Joseph
Eviston, John B.	Huntington	Huntington	Fisher, Walter S.	Columbus	Bartholomew-Brown
Ewer, Robert W.	Evansville	Vanderburgh	Fisher, William C.	Evansville	Vanderburgh
Ewing, Nathaniel D.	Vincennes	Knox	Fitz Gerald, Maurice D.	Evansville	Vanderburgh
F			Fitzgerald, Brice E.	Logansport	Cass
Fadell, Matthew J.	Gary	Lake	Fitzgerald, William J.	Indianapolis	Marion
Fadul, Armand	Gary	Lake	Fitzpatrick, H. W. (S)	Elwood	Madison
Fagaly, William J.	Lawrenceburg	Dearborn-Ohio	Fitzpatrick, James S.	Portland	Jay
Fahringer, Robert R.	Bedford	Lawrence	Fitzpatrick, William J.	Hammond	Lake
Failey, Robert B.	Indianapolis	Marion	Flack, Russell A.	Lafayette	Tippecanoe
			Flaherty, Robert A.	Fort Wayne	Allen

Name	City	County	Name	City	County
Flanagan, Estle P. (S)	Walton	Cass	Frith, Louis G.	South Bend	St. Joseph
Flanagan, Paul M.	Indianapolis	Marion	Fromhold, Willis A.	Indianapolis	Marion
Flanders, Robert J.	Indianapolis	Marion	Frost, Robert J.	Michigan City	La Porte
Flanigan, Meredith B.	Indianapolis	Marion	Fry, Robert D.	Indianapolis	Marion
Flannigan, Harley F.	LaGrange	LaGrange	Fujawa, Matthew J.	Mishawaka	St. Joseph
Fleetwood, Raymond A.	Nappanee	Elkhart	Fullam, Richard G.	Fort Wayne	Allen
Fleischer, Jacob C.	East Chicago	Lake	Fullerton, Robert L.	Monticello	White
Fleischl, Herbert	Indianapolis	Marion	Fulton, William H.	Charlotte, N. C.	Marion
Fleming, Claude F. (S)	Elkhart	Elkhart	Fultz, Roy L.	Salem	Washington
Fletcher, Charles F. (S)	Sunman	Ripley	Funk, John W.	Muncie	Delaware- Blackford
Flick, John J.	Indianapolis	Marion	Funkhouser, Elmer (S)	Indianapolis	Marion
Flora, Fred W.	Frankfort	Clinton	Furr, Jack D.	Kingman	Fountain- Warren
Flora, Joseph O.	Indianapolis	Marion	Fuson, Wenfred J.	Greencastle	Putnam
Fogel, Ernest	Logansport	Cass	Futterknecht, James O.	Elkhart	Elkhart
Folck, John K.	Princeton	Gibson	G		
Folkening, Norval C.	Indianapolis	Marion			
Foltz, Lloyd E.	Brownsville	Hendricks	Gabe, William E.	Orinda, Calif.	Marion
Fong, Theodore C. C.	Madison	Jefferson- Switzerland	Gabovitch, Edward R.	Indianapolis	Marion
Forbes, Robert S.	Indianapolis	Marion	Gachaw, Gabra S.	Indianapolis	Marion
Forbes, Violet Crabbe	Wolcott	White	Gaddy, Euclid T.	Indianapolis	Marion
Foreman, Walter A.	Brookville	Fayette- Franklin	Gaddy, Nelson D.	Indianapolis	Marion
Forry, Frank (S)	Indianapolis	Marion	Gaffney, Raymond	South Bend	St. Joseph
Forsee, Norman E.	Jeffersonville	Clark	Gailey, Ivan	Indianapolis	Marion
Fortuna, Frank W.	Indianapolis	Marion	Galante, Vincent J.	Gary	Lake
Fosbrink, Ephriam L.	Syracuse	Kosciusko	Galbreath, Jesse P. (S)	Burnettsville	White
Fosgate, Harold	Torrance, Calif.	Marion	Galliher, Marjorie J.	Muncie	Delaware- Blackford
Foster, Lee N.	Indianapolis	Marion	Gallinatti, John J.	Gary	Lake
Foster, Ray D.	Indianapolis	Marion	Gambill, J. Randolph	Madison	Jefferson- Switzerland
Foster, Ray T.	Newcastle	Henry	Gambill, William D.	Indianapolis	Marion
Foster, Robert	Franklin	Johnson	Gammieri, Robert L.	Indianapolis	Marion
Fountaine, Thomas J.	Bedford	Lawrence	Gammell, Lindley L.	Columbus	Bartholomew- Brown
Fouts, Dallas B.	Indianapolis	Marion	Ganser, Ralph V.	Elkhart	Elkhart
Fouts, Paul J.	Indianapolis	Marion	Ganser, Richard A.	Mishawaka	St. Joseph
Fowler, Richard R.	Bloomington	Owen-Monroe	Gante, Henry W. (S)	Anderson	Madison
Fox, C. Philip	Washington	Daviess- Martin	Ganz, Max	Marion	Grant
Fox, Jack	Munster	Lake	Garber, J. Neill	Indianapolis	Marion
Fox, Richard	Greenwood	Johnson	Garceau, George J.	Indianapolis	Marion
Foy, Hayward W.	Fort Wayne	Allen	Gard, Daniel A.	Indianapolis	Marion
Frale, Frank L. Jr.	Lawrenceburg	Dearborn-Ohio	Gardiner, H. Glenn	East Chicago	Lake
Fralich, Joseph C.	Milwaukee, Wis.	Marion	Gardiner, Sprague H.	Indianapolis	Marion
France, Lloyd C.	Plymouth	Marshall	Gardner, Austin L.	Indianapolis	Marion
Frank, Herbert	South Bend	St. Joseph	Gardner, Buckman	Indianapolis	Marion
Frank, John R. (S)	Valparaiso	Porter	Gardner, Melvin D.	Michigan City	La Porte
Frank, Lyall, Jr.	South Bend	St. Joseph	Gardner, Russell A.	Michigan City	La Porte
Frank, Lyall L.	South Bend	St. Joseph	Garfield, Martin D.	Indianapolis	Marion
Franke, Gordon R.	Fort Wayne	Allen	Garland, Edgar A.	Evansville	Vanderburgh
Frankhouser, Charles M. A.	Fort Wayne	Allen	Garling, Luvern C.	Muncie	Delaware- Blackford
Franklin, Philip L.	Gary	Lake	Garner, W. Stanley	Indianapolis	Marion
Franklin, William L.	Indianapolis	Marion	Garner, William H., Sr.	New Albany	Floyd
Frankowski, Clementine	Whiting	Lake	Garner, William H., Jr.	New Albany	Floyd
Frantz, Mount E.	Bryan A.F.B., Texas	Hendricks	Garrett, John D. (S)	Indianapolis	Marion
Frasch, Mahlon G.	Lafayette	Tippecanoe	Garrett, Robert A.	Indianapolis	Marion
Frash, De Von W.	South Bend	St. Joseph	Garrison, James L.	Cumberland	Marion
Frazier, John L.	Kokomo	Howard	Garrison, Leon J.	Gas City	Grant
Freeborn, Warren S.	Oaklandon	Marion	Garton, Harry W.	Fort Wayne	Allen
Freeby, C. William	Decatur	Adams	Garvin, Donald B.	Brazil	Clay
Freed, Carl A.	Indianapolis	Marion	Gastineau, David C.	Fort Wayne	Allen
Freed, John E., Jr.	Terre Haute	Vigo	Gatch, Willis D. (S)	Indianapolis	Marion
Freed, John E. (S)	Terre Haute	Vigo	Gates, George E.	South Bend	St. Joseph
Freeland, Bill	Batesville	Ripley	Gattman, George B.	Elkhart	Elkhart
Freeman, Leslie W.	Indianapolis	Marion	Gatzimos, Christos D.	Logansport	Cass
Freeman, Max E.	Indianapolis	Marion	Gaul, L. Edward	Evansville	Vanderburgh
French, Richard N.	Indianapolis	Marion	Gaunt, Everett W.	Alexandria	Madison
Fretz, Richard C.	Kokomo	Howard	Geckler, Charles E.	Muncie	Delaware- Blackford
Frey, Harley B.	Lafayette	Tippecanoe	Geick, Raymond G.	Fort Branch	Gibson
Frey, William B.	South Bend	St. Joseph	Geider, Roy A.	Indianapolis	Marion
Friedman, Isadore E.	Hammond	Lake	Geiger, Dillon D.	Bloomington	Owen-Monroe
Friedman, Morris S.	South Bend	St. Joseph			

Name	City	County	Name	City	County
Geisinger, Lewis N. (S)	Auburn	De Kalb	Goodman, Eli S.	Charlestown	Clark
Geisler, Hans E.	Indianapolis	Marion	Goodman, Hubert T.	Terre Haute	Vigo
Genovese, Pasquale	Indianapolis	Marion	Goodrum, William R.	Cayuga	Parke- Vermillion
Genna, Mary E. Miller	Indianapolis	Marion			
Gentile, John P.	New Albany	Floyd	Gootee, Francis H.	Jasper	Dubois
George, Charles L.	Indianapolis	Marion	Gootee, Thomas H.	Jasper	Dubois
Gerding, William J.	Fort Wayne	Allen	Gordon, Joseph L.	Wheeler	Porter
Gerig, Eldon L.	Indianapolis	Marion	Gormley, Joseph J.	Indianapolis	Marion
Geronimo, Manuel M.	East Chicago	Lake	Gosman, James H.	Indianapolis	Marion
Geronimo, Rita R. V.	East Chicago	Lake	Gossard, Meredith B.	Tipton	Tipton
Gerrish, Donald A.	Terre Haute	Vigo	Gossom, Donn R.	Terre Haute	Vigo
Gerrish, Wakefield D. (S)	Clinton	Parke- Vermillion	Gould, John C.	Fort Wayne	Allen
Gery, Richard E.	Lafayette	Tippecanoe	Govorchin, Alexander	East Chicago	Lake
Getty, William H.	Evansville	Vanderburgh	Graber, Virgil R.	Elkhart	Elkhart
Gevirtz, Milton B.	Hammond	Lake	Graessle, Harold P.	Seymour	Jackson
Geyer, Joseph H.	New Albany	Floyd	Graf, Jerome A.	Bloomfield	Greene
Gibbs, Charles (S)	Greenfield	Hancock	Graf, John P.	South Bend	St. Joseph
Gibbs, Joseph W.	Martinsville	Morgan	Graham, Edward W.	Indianapolis	Marion
Gibson, Alois E.	Indianapolis	Marion	Graham, George M.	Fort Wayne	Allen
Gibson, Greta Maxine	Indianapolis	Marion	Graham, James C.	Fort Wayne	Allen
Gibson, Robert K.	Muncie	Delaware- Blackford	Graham, John D.	Indianapolis	Marion
			Graham, William E.	Indianapolis	Marion
Gick, Herman H. (S)	Indianapolis	Marion	Grant, Benjamin F.	Gary	Lake
Gifford, Fred E.	Indianapolis	Marion	Grant, M. Arthur	Fairmount	Grant
Gilbert, Ivan	Terre Haute	Vigo	Grant, Phyllis A.	New Castle	Henry
Gilbert, Robert G.	Tell City	Perry	Graves, Noel S.	Vevay	Jefferson- Switzerland
Gill, Dee D.	Greenfield	Hancock			
Gill, John R.	Indianapolis	Marion	Graves, Orville M.	Princeton	Gibson
Gill, Thomas A.	Muncie	Delaware- Blackford	Gray, Clyde C. (S)	Cloverdale	Putnam
			Gray, Daniel E.	Crown Point	Lake
Gilles, Pierre	Gary	Lake	Gray, Kenneth L.	Indianapolis	Marion
Gillespie, Charles F.	Indianapolis	Marion	Gray, Leon	Martinsville	Morgan
Gillespie, Garland R.	Brownstown	Jackson	Gray, Mary Case	Elkhart	Elkhart
Gillespie, Jacob E.	Indianapolis	Marion	Grayson, Ted L.	St. Louis, Mo.	Marion
Gillim, Parvin D.	Indianapolis	Marion	Grayston, Wallace S. (S)	Huntington	Huntington
Gillotte, Joseph P.	Terre Haute	Vigo	Green, Carl L.	Vincennes	Knox
Gillum, Eugene M.	Portland	Jay	Green, Frank H.	Rushville	Rush
Gilman, Marcus M.	South Bend	St. Joseph	Green, George F.	South Bend	St. Joseph
Gilmore, Robert W.	Michigan City	La Porte	Green, Leonard J.	Valparaiso	Porter
Gilmore, Russell A.	Michigan City	La Porte	Green, Morris	Indianapolis	Marion
Gingerick, Charles M.	Liberty Center	Wells	Green, Norval E.	South Bend	St. Joseph
Ginsberg, Stewart T.	Indianapolis	Marion	Greene, Frederick G. (S)	Bloomington	Parke- Vermillion
Giorgio, Douglas J.	Evansville	Vanderburgh			
Girod, Arthur H.	Decatur	Adams	Greene, Morgan E.	Indianapolis	Marion
Girod, Donald A.	Dunkirk	Jay	Greene, Robert W.	Rensselaer	Jasper- Newton
Gish, Howard M.	Brookston	White			
Gitlin, Max M.	Bluffton	Wells	Greene, William R.	Henryville	Clark
Gitlin, William A.	Bluffton	Wells	Greenlee, Robert L.	Fort Wayne	Allen
Glackman, John C., Jr.	Rockport	Spencer	Gregg, Albert F.	Connersville	Fayette- Franklin
Gladstone, Naf H.	Fort Wayne	Allen			
Glassley, Stephen H.	Fort Wayne	Allen	Gregg, Edwin E.	Thorntown	Boone
Glendening, John L. (S)	Indianapolis	Marion	Gregoline, Amadeo F.	Gary	Lake
Glendening, Richard L.	Logansport	Cass	Gregory, Robert L.	Indianapolis	Marion
Glenn, Fred C. (S)	Tell City	Perry	Greiber, Marvin F.	Muncie	Delaware- Blackford
Glock, Homer E. (S)	Fort Wayne	Allen			
Glock, Maurice E.	Fort Wayne	Allen	Greisen, Jack G.	Whiting	Lake
Glock, Wayne R.	Fort Wayne	Allen	Greist, John H.	Indianapolis	Marion
Glover, John L.	Indianapolis	Marion	Griep, Arthur H.	Evansville	Vanderburgh
Glover, William J.	Gary	Lake	Griest, Walter D.	Fort Wayne	Allen
Gobbel, Novy E. (S)	English	Harrison- Crawford	Griffin, Charles G.	Valparaiso	Porter
			Griffin, Joseph P.	Chesterton	Porter
Godwin, Donald W.	Indianapolis	Marion	Griffin, Leslie W.	Indianapolis	Marion
Goebel, Carl W.	Fort Wayne	Allen	Griffis, Vierl C. (S)	Richmond	Wayne-Union
Godersky, George E.	South Bend	St. Joseph	Griffith, Harold R.	Fort Wayne	Allen
Goethals, Charles J.	Mishawaka	St. Joseph	Griffith, James W.	Sheridan	Hamilton
Goldberg, Harold B.	Gary	Lake	Griffith, Richard S.	Indianapolis	Marion
Goldenberg, Norman S.	Indianapolis	Marion	Griffith, Ross E.	Indianapolis	Marion
Golding, Robert F.	Gary	Lake	Grigsby, Hardin B.	Lebanon	Boone
Goldman, Samuel	Indianapolis	Marion	Grillo, Donald	South Bend	St. Joseph
Goldsmith, David A.	Marion	Grant	Grimes, Hubert N.	Indianapolis	Marion
Goldstone, Adolph	Gary	Lake	Grimm, William C. H.	Evansville	Vanderburgh
Goldstone, Joseph	Gary	Lake	Grindrod, John M.	Terre Haute	Vigo
Goldstone, Sidney R.	Gary	Lake	Gripe, Richard P.	Lafayette	Tippecanoe
Golper, Marvin N.	Kokomo	Howard	Grisell, Ted L.	Indianapolis	Marion
Good, Richard P.	Kokomo	Howard	Grosso, William G.	East Chicago	Lake
Goodell, Charles L.	Detroit, Mich.	Lake	Grorud, Alton C.	South Bend	St. Joseph

Name	City	County	Name	City	County
Grothouse, Carl B.	Kokomo	Howard	Hanna, Thomas A.	Indianapolis	Marion
Grotts, Bruce F.	Michigan City	La Porte	Hannah, Jack W.	Elkhart	Elkhart
Grove, James H.	South Bend	St. Joseph	Hanneken, Vincent J.	Wabash	Wabash
Grove, Robert H.	Rossville	Clinton	Hannemann, Robert E.	Indianapolis	Marion
Gruber, Charles M.	Indianapolis	Marion	Hansell, Robert M.	Indianapolis	Marion
Guckien, Joseph L.	Evansville	Vanderburgh	Hanson, Martin F.	Elwood	Madison
Gustafson, Carl J.	Marion	Grant	Harcourt, Allan K.	Indianapolis	Marion
Gustafson, Milton	Muncie	Delaware-Blackford	Harcourt, Robert S.	Indianapolis	Marion
Gustaitis, John W.	Whiting	Lake	Harden, Murray E.	Lafayette	Tippecanoe
Guthrie, James R.	Richmond	Wayne-Union	Hardin, Wayne E.	Ossian	Wells
Guthrie, James U.	Peru	Miami	Harding, M. Richard	Indianapolis	Marion
Guthrie, William H.	Butlerville	Jennings	Harding, Myron S.	Indianapolis	Marion
Gutierrez, Peter E.	Crown Point	Lake	Hardtke, Eldred F.	Bloomington	Owen-Monroe
Gutstein, Richard R. (S)	Kendallville	Noble	Hardy, John J. (S)	North Liberty	St. Joseph
Guttman, John B.	Wakarusa	Elkhart	Hare, Daniel M.	Evansville	Vanderburgh
Gwin, Merle D. (S)	Miami Beach, Fla.	Newton	Hare, Earl H. (S)	Indianapolis	Marion
			Hare, Francis W., Jr.	Madison	Jefferson-Switzerland
H			Hare, Laura	Indianapolis	Marion
Haas, Charles F.	Lafayette	Tippecanoe	Harger, Robert W.	Indianapolis	Marion
Habegger, Elmer D.	Indianapolis	Marion	Harkcom, Harry E.	St. Paul	Decatur
Hackett, Walter G.	Fort Wayne	Allen	Harkness, Robert G.	Terre Haute	Vigo
Hade, Frederick L. (S)	Bridgeport	Marion	Harless, Clarence M.	Chesterton	Porter
Hadey, James H.	Gary	Lake	Harless, Fred	Monroeville	Allen
Hadley, David	Indianapolis	Marion	Harlan, William L.	Evansville	Vanderburgh
Hadley, Harvey (S)	Richmond	Wayne-Union	Harmon, Carl J.	Richmond	Wayne-Union
Haffner, Herman G.	Fort Wayne	Allen	Harmon, Wayne	Lynn	Randolph
Haggard, David B.	Plainfield	Hendricks	Harned, Ben K.	Evansville	Vanderburgh
Haggard, Edmund B.	Indianapolis	Marion	Harold, Albert H. (S)	Indianapolis	Marion
Hagie, Frank E.	Richmond	Wayne-Union	Harold, Norris E. (S)	Indianapolis	Marion
Haley, Alvin J.	Fort Wayne	Allen	Harper, James W.	East Chicago	Lake
Haley, Paul E.	South Bend	St. Joseph	Harrington, James F.	Logansport	Cass
Halfast, Richard W.	Kokomo	Howard	Harris, Carl B.	Indianapolis	Marion
Hall, Bernard R.	Logansport	Cass	Harris, Neil	Elkhart	Elkhart
Hall, Donald L.	Petersburg	Pike	Harris, Paul N.	Indianapolis	Marion
Hall, Frank M.	Indianapolis	Marion	Harris, Robert F.	Noblesville	Hamilton
Hall, Jack H.	Indianapolis	Marion	Harris, Robert L.	Evansville	Vanderburgh
Hall, James M.	South Bend	St. Joseph	Harris, Robert W.	New Albany	Floyd
Hall, Robert S.	Muncie	Delaware-Blackford	Harrison, Benjamin L.	New Castle	Henry
Hall, Thomas C.	Chesterton	Porter	Harshman, James A.	Great Lakes, Ill.	Marion
Hall, William R.	Indianapolis	Marion	Harshman, Louis P.	Fort Wayne	Allen
Halleck, Harold J.	Winamac	Pulaski	Harstad, Casper	Rockville	Parke-Vermillion
Haller, Richard C.	Fort Wayne	Allen	Hart, L. Paul	Evansville	Vanderburgh
Haller, Robert L.	Kempton	Tipton	Hart, Robert B.	Columbus	Bartholomew-Brown
Haller, Thomas C.	Crawfordsville	Montgomery	Hart, William D.	Anderson	Madison
Hamer, Homer G. (S)	Indianapolis	Marion	Harter, Eli B.	Lafayette	Tippecanoe
Hamilton, Antha A.	Vevay	Jefferson-Switzerland	Hartley, Clarence A., Jr.	Evansville	Vanderburgh
Hamilton, Charles O.	South Bend	St. Joseph	Hartman, John J.	Angola	Steuben
Hamilton, Emory D.	Fort Wayne	Allen	Hartsough, Ralph I.	Lakeville	St. Joseph
Hamilton, George M.	Fort Wayne	Allen	Hartz, F. Minton	Evansville	Vanderburgh
Hamilton, Howard B.	Indianapolis	Marion	Harvey, Bennett B.	Lafayette	Tippecanoe
Hamilton, James R.	Mitchell	Lawrence	Harvey, Harry C.	Fort Wayne	Allen
Hamilton, M. Luther (S)	Newberry	Greene	Harvey, Ralph J. (S)	Zionsville	Boone
Hamilton, Orville G.	Bluffton	Wells	Harvey, Verne K., Jr.	Indianapolis	Marion
Hamilton, Thomas	Columbia City	Whitley	Harvey, Verne K. Sr.	Indianapolis	Marion
Hammel, Howard T.	Bedford	Lawrence	Hasewinkel, Carroll W.	Carmel	Hamilton
Hammer, Jay W.	Middletown	Henry	Hasewinkle, August M.	Fort Wayne	Allen
Hammersley, George K.	Frankfort	Clinton	Hash, John S.	Noblesville	Hamilton
Hammond, James B.	Indianapolis	Marion	Hashemi, Hossein	Warsaw	Kosciusko
Hammond, Keith	Muncie	Delaware-Blackford	Haslem, Ezra R.	Terre Haute	Vigo
Hammond, R. Case	Evansville	Vanderburgh	Haslem, John R.	Terre Haute	Vigo
Hampshire, Donald R.	Indianapolis	Marion	Haslinger, Clarence J.	Indianapolis	Marion
Hampton, James N.	Argos	Marshall	Hass, Caroline E.	W. Lafayette	Tippecanoe
Hancock, John G.	Indianapolis	Marion	Hass, Thomas W.	W. Lafayette	Tippecanoe
Haney, William	Madison	Jefferson-Switzerland	Hastings, Warren C.	Fort Wayne	Allen
Hanley, Harriet F.	South Bend	St. Joseph	Hatfield, Jack J.	Indianapolis	Marion
Hanley, Larry L.	Indianapolis	Marion	Hatfield, Nicholas W.	Indianapolis	Marion
Hann, Eldon C.	Indianapolis	Marion	Hattendorf, Anton P.	Fort Wayne	Allen
			Haugseth, Ellsworth K.	South Bend	St. Joseph
			Hauss, Augustus P. (S)	New Albany	Floyd
			Havens, A. Lyle	Jeffersonville	Clark
			Havens, Thomas R.	Jeffersonville	Clark
			Havens, Oscar	Cicero	Hamilton
			Havens, Russell E.	Fort Wayne	Allen

Name	City	County	Name	City	County
Hawes, James K. (S)	Columbus	Bartholomew-Brown	Hershberger, Philip G.	Fort Wayne	Allen
Hawes, Marvin E.	Columbus	Bartholomew-Brown	Hershey, Ernest A. (S)	Churubusco	Whitley
Hawk, James H.	Indianapolis	Marion	Herzberg, Milton	Clinton	Parke-Vermillion
Hawkins, Glen E.	South Bend	St. Joseph	Herzer, Clarence C.	Evansville	Vanderburgh
Hawkins, Richard D.	Bedford	Lawrence	Hess, Paul P.	New Albany	Floyd
Hawtof, David B.	Indianapolis	Marion	Hetherington, A. M. (S)	Indianapolis	Marion
Hay, Gene R.	Indianapolis	Marion	Hetherington, John A.	Indianapolis	Marion
Hayes, Frank W.	East Chicago	Lake	Hetman, Mitchell J.	Westville	La Porte
Hayes, J. D., Jr.	St. Louis, Mo.	Lake	Heubi, John E.	Indianapolis	Marion
Hayes, Jesse D.	East Chicago	Lake	Hibbs, William G.	Franklin	Johnson
Hayes, Theodore R.	Muncie	Delaware-Blackford	Hibner, Kermit Q.	Bloomington	Owen-Monroe
Haymond, George M.	Warsaw	Kosciusko	Hibner, Nolan A.	Monticello	White
Haymond, Joseph L.	Indianapolis	Marion	Hickam, John B.	Indianapolis	Marion
Haynes, John T.	Indianapolis	Marion	Hickman, A. Lee	Hammond	Lake
Hays, Everett L.	Indianapolis	Marion	Hickman, Donald M.	Fort Wayne	Allen
Haywood, John G.	Noblesville	Hamilton	Hickman, Jack W.	Indianapolis	Marion
Headley, Lloyd M.	Lebanon	Boone	Hickman, Walter F. (S)	Indianapolis	Marion
Healey, Robert J.	Indianapolis	Marion	Hicks, Murwyn L.	Indianapolis	Marion
Heard, Albert	Evansville	Vanderburgh	Hicks, Wilbur P.	Indianapolis	Marion
Heaton, Elton	Huntingburg	Dubois	Higbee, Paul (S)	Sullivan	Sullivan
Heck, Martin C.	Jasper	Dubois	Higgins, James L.	AP0 63, San Francisco, Calif.	Pike
Heckaman, Edward L.	Cedar Lake	Lake	Higgins, John R.	New Albany	Floyd
Hedde, Eugene L.	Logansport	Cass	Higgins, Kenneth E.	Fort Wayne	Allen
Hedgcock, Robert A.	Frankfort	Clinton	High, Ralph L.	Muncie	Delaware-Blackford
Hedrick, James T.	Gary	Lake	Hilbert, John W.	South Bend	St. Joseph
Hedrick, Philip W.	Indianapolis	Marion	Hildebrand, John O.	South Bend	St. Joseph
Heilman, William C., Jr.	New Castle	Henry	Hill, Gladys Marie	Richmond	Wayne-Union
Heilman, W. C., Sr. (S)	New Castle	Henry	Hill, Harold D.	Richmond	Wayne-Union
Heimbarger, Robert F.	Indianapolis	Marion	Hill, Howard E.	Muncie	Delaware-Blackford
Heinrich, Weston A.	Evansville	Vanderburgh	Hill, James K.	Indianapolis	Marion
Heinrichs, Harry H. (S)	Indianapolis	Marion	Hill, Kenneth G.	New Castle	Henry
Held, George A.	Jasper	Dubois	Hill, Lloyd	Peru	Miami
Heller, Nelson L. (S)	Dunkirk	Jay	Hill, Paul G.	Cambridge City	Wayne-Union
Helmen, Charles H.	Indianapolis	Marion	Hill, Robert E.	Yorktown	Delaware-Blackford
Helmen, Harry W. (S)	Rolling Prairie	La Porte	Hill, Theodore A.	South Bend	St. Joseph
Helmer, Frederic A.	Cincinnati, Ohio	Allen	Hill, Wallace C.	South Bend	St. Joseph
Helmer, John F.	South Bend	St. Joseph	Hillenbrand, Charles	Michigan City	La Porte
Heminway, Norman L.	Elkhart	Elkhart	Hillery, John	Warsaw	Kosciusko
Hendershot, Eugene L.	Evansville	Vanderburgh	Hillery, Robert L.	Fort Wayne	Allen
Henderson, Francis G.	Indianapolis	Marion	Hillis, Lowell J.	Logansport	Cass
Henderson, Norman C.	Michigan City	La Porte	Hillman, Marion W.	South Bend	St. Joseph
Henderson, Ramon A.	Muncie	Delaware-Blackford	Hillman, Wm. H. (S)	South Bend	St. Joseph
Henderson, Robert N.	Brookston	White	Hillsamer, Phyllis G.	Waterloo	De Kalb
Henderson, Roscoe C.	Indianapolis	Marion	Himebaugh, Gilbert J.	Evansville	Vanderburgh
Henderson, William P.	Indianapolis	Marion	Himler, James M.	Indianapolis	Marion
Hendricks, Fred A.	Indianapolis	Marion	Hinchman, Jean F.	Parker	Randolph
Hendricks, John W.	Indianapolis	Marion	Hines, Archie V.	Auburn	De Kalb
Hendrix, Charles E.	Vincennes	Knox	Hines, Don C.	Indianapolis	Marion
Henley, Glenn (S)	Fairmount	Grant	Hines, John H.	Auburn	De Kalb
Henn, R. Anthony	Greenfield	Hancock	Hingeley, John E.	Butler	Jennings
Henry, Alvin L.	Columbus	Bartholomew-Brown	Hippensteel, Harland	Auburn	De Kalb
Henry, Howard J.	Knox	Starke	Hipskind, Richard E.	Fort Wayne	Allen
Henry, Russell S.	Indianapolis	Marion	Hirsch, Herman L.	Mt. Vernon	Posey
Hensler, Benton M.	Anderson	Madison	Hirrich, Lloyd W.	Batesville	Ripley
Hepburn, C. K.	Indianapolis	Marion	Hobbs, Arthur A.	Evansville	Vanderburgh
Hepner, Herman	Kendallville	Noble	Hochhalter, Marian	Logansport	Cass
Hepner, Herman S.	Bloomington	Owen-Monroe	Hodges, Fletcher (S)	Indianapolis	Marion
Herd, Cloyd R.	Peru	Miami	Hodgin, Phillip T.	Orleans	Orange
Herendeen, Elbie V.	Rochester	Fulton	Hodurski, Zigfield	Gary	Lake
Heritier, C. Jules	Columbia City	Whitley	Hoetzer, Eldore M.	New Haven	Allen
Hermayer, Stephen	Evansville	Vanderburgh	Hoffman, Arthur F.	Fort Wayne	Allen
Hernandez, I. C.	East Chicago	Lake	Hoffman, Doris	Vincennes	Knox
Herr, John W.	Tell City	Perry	Hoffman, Herman	Indianapolis	Marion
Herrick, Charles L.	Akron	Fulton	Hoffman, Kenneth C.	Michigan City	La Porte
Herrmann, Gordon T.	Evansville	Vanderburgh	Hoffman, Max N.	Covington	Fountain-Warren
Herrold, George W.	Lafayette	Tippecanoe			

Name	City	County	Name	City	County
Hofmann, J. William (S)	Indianapolis	Marion	Hull, Ronald H.	Indianapolis	Marion
Hogan, Michael A.	Indianapolis	Marion	Hummel, Russel M.	Marion	Grant
Hogan, Thomas W.	Terre Haute	Vigo	Hummons, Francis D.	Indianapolis	Marion
Hogle, Frank D.	Lafayette	Tippecanoe	Humphrey, Edward M.	Covington	Fountain-Warren
Hoham, Frederick D.	Gary	Lake	Humphrey, Paul E.	Terre Haute	Vigo
Hoit, Leonard	Gary	Lake	Humphreys, Joe E.	Vincennes	Knox
Holdeman, Lillian S.	South Bend	St. Joseph	Humphreys, John L.	Fort Wayne	Allen
Holdeman, Richard W.	South Bend	St. Joseph	Humphreys, John W.	Crawfordsville	Montgomery
Holladay, Lloyd J.	Lafayette	Tippecanoe	Hunsberger, Walter G.	Lafayette	Tippecanoe
Holland, Deward J. (S)	Bloomington	Owen-Monroe	Hunt, Edgar J.	Terre Haute	Vigo
Holland, Philip T.	Bloomington	Owen-Monroe	Hunt, Gayle J.	Richmond	Wayne-Union
Hollenberg, Alfred E.	Hagerstown	Wayne-Union	Hunter, Donn R.	Greenfield	Hancock
Hollenberg, Edward L.	Winamac	Pulaski	Hunter, Frank P. (S)	Lafayette	Tippecanoe
Holloway, William A. (S)	Logansport	Cass	Hunter, Lowell G.	Lawrenceburg	Dearborn-Ohio
Holman, Jerome E., Sr. (S)	Indianapolis	Marion	Huoni, John S.	Jeffersonville	Clark
Holman, Jerome E., Jr.	Indianapolis	Marion	Hurley, Anson G.	Muncie	Delaware-Blackford
Holmes, Claude D. (S)	Coral Gables, Fla.	Clinton	Hurley, James W.	Elkhart	Elkhart
Holmes, John L.	Muncie	Delaware-Blackford	Hurley, John R.	Daleville	Delaware-Blackford
Holsinger, Robert E.	Fort Wayne	Allen	Hursey, Virgil G.	Milford	Kosciusko
Holtzman, Norman N.	South Bend	St. Joseph	Hurt, LaVerne B.	Indianapolis	Marion
Holtzman, Paul W.	Bloomington	Owen-Monroe	Hurteau, William W.	Indianapolis	Marion
Honan, Paul R.	Lebanon	Boone	Huse, William M.	Indianapolis	Marion
Hood, Ainslee A.	Indianapolis	Marion	Husted, Robert G.	Hammond	Lake
Hooke, Samuel W. (S)	Noblesville	Hamilton	Hutchison, Donald R.	Fountain City	Wayne-Union
Hooker, Donald J.	Indianapolis	Marion	Hutto, William H.	Kokomo	Howard
Hoopes, Jane M.	Evansville	Vanderburgh	Hyatt, Gilbert T.	Evansville	Vanderburgh
Hoover, Dewey A.	Terre Haute	Vigo	Hyde, Carroll C.	South Bend	St. Joseph
Hoover, J. Guy	Evansville	Vanderburgh	Hyndman, Lloyd G.	Hammond	Lake
Hoover, Peter B.	Boonville	Warrick	Hynes, Roy T.	Indianapolis	Marion
Hopkins, Joseph R.	Hammond	Lake			
Hopkins, Lester H.	Butlerville	Jennings			
Hoppenrath, William (S)	Elwood	Madison			
Horning, Richard R.	Logansport	Cass			
Horst, William N.	Crown Point	Lake			
Horswell, Richard G.	Bristol	Elkhart			
Horswell, Richard R.	Lafayette	Tippecanoe			
Horwitz, Thomas	Indianapolis	Marion			
Hostetler, Carl M.	Goshen	Elkhart			
Hostetter, Irwin S.	Muncie	Delaware-Blackford			
Hotalen, William B.	Evansville	Vanderburgh			
Houser, D. Stanley	South Bend	St. Joseph			
Houser, Wayne W.	Monon	White			
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio			
Hovda, Richard B.	Evansville	Vanderburgh			
Hover, Galen	Marion	Grant			
How, John T. (S)	Lakeville	St. Joseph			
How, Louis E.	South Bend	St. Joseph			
Howard, Wm. Harry	Hammond	Lake			
Howe, Fordyce L.	Fort Wayne	Allen			
Howell, Arthur	Indianapolis	Marion			
Howell, Joseph D.	Indianapolis	Marion			
Howell, Robert D.	Indianapolis	Marion			
Hoyt, Charles J.	Indianapolis	Marion			
Hoyt, John M.	Kokomo	Howard			
Hoyt, Lester H.	Indianapolis	Marion			
Hoyt, Millard L.	Indianapolis	Marion			
Hrisomalos, Frank N.	Bloomington	Owen-Monroe			
Hubbard, Jesse D.	Indianapolis	Marion			
Huber, Carl P.	Indianapolis	Marion			
Huckleberry, Irvin E.	Salem	Washington			
Huddle, John R.	Indianapolis	Marion			
Hudson, Arlington M.	Connersville	Fayette-Franklin			
Hudson, Foster J.	Indianapolis	Marion			
Huffman, Galen C.	Columbus, O.	Marion			
Huffman, Verlin P.	S. Whitley	Whitley			
Hughes, Richard R.	Lafayette	Tippecanoe			
Huggins, Victor S.	Evansville	Vanderburgh			
Hull, De Wayne L.	Indianapolis	Marion			
Hull, James E.	Lafayette	Tippecanoe			

I

Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingram, Richard	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert H.	Shelbyville	Shelby
Inlow, William D. (S)	Shelbyville	Shelby
Irick, Robert L.	PO 179, New York, N. Y.	Marion
Irmscher, George W.	Lawrenceburg	Dearborn-Ohio
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth (S)	Anderson	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, Nathaniel C.	Jeffersonville	Clark
Iterman, George E. (S)	New Castle	Henry
Ivy, John H.	Elkhart	Elkhart

J

Jackson, Charles E.	Bluffton	Wells
Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, Frederick E. (S)	Indianapolis	Marion
Jackson, James W. (S)	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, John K.	Aurora	Dearborn-Ohio
Jacobs, E. Robert	Columbus	Bartholomew-Brown
Jaeger, Alfred S. (S)	Indianapolis	Marion
Jahns, Albin A.	Gary	Lake
James, John M.	Tell City	Perry
James, Nicholas A. (S)	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jannasch, Maurice C.	Richmond, Va.	Lake
Jaquith, Orville S. (S)	Indianapolis	Marion
Jarrett, John C.	Marion	Grant
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion

Name	City	County	Name	City	County
Jay, James M.	Indianapolis	Marion	Jurgensen, Walter T.	Fort Wayne	Allen
Jenkins, Robert E.	Indianapolis	Marion	Justin, Renate G.	Terre Haute	Vigo
Jennings, Frank L. (S)	Indianapolis	Marion	K		
Jernigan, William R.	Memphis, Tenn.	Vanderburgh	Kabel, Robert N.	Terre Haute	Vigo
Jett, Clyde W.	Seelyville	Vigo	Kahler, Maurice V.	Indianapolis	Marion
Jewell, Earl B. (S)	Logansport	Cass	Kahn, Alexander J.	Indianapolis	Marion
Jewell, George M.	Kokomo	Howard	Kahn, Howard L.	Indianapolis	Marion
Jewett, Joe H.	Indianapolis	Marion	Kaiser, George C.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	De Kalb	Kaiser, George D.	Whiting	Lake
Jobes, James E.	Indianapolis	Marion	Kalb, Everett L.	Indianapolis	Marion
Jobes, Norman E. (S)	Indianapolis	Marion	Kamen, Jack M.	Gary	Lake
Johns, David R. (S)	East Chicago	Lake	Kamm, Bernard A.	South Bend	St. Joseph
Johns, Nicholas C.	South Bend	St. Joseph	Kammen, Leo	Indianapolis	Marion
Johnson, Arnold L.	Gary	Lake	Kammen, Robert	Indianapolis	Marion
Johnson, Earl H.	Indianapolis	Marion	Kammer, Walter F.	Muncie	Delaware- Blackford
Johnson, Gardner C. (S)	Evansville	Vanderburgh	Kantzer, Floyd B.	Garrett	De Kalb
Johnson, George M.	Richmond	Wayne-Union	Karberg, Richard J.	Lafayette	Tippecanoe
Johnson, Harold V.	Evansville	Vanderburgh	Karlick, Joseph	Arcadia	Hamilton
Johnson, Herbert S.	Lafayette	Tippecanoe	Karn, John W.	South Bend	St. Joseph
Johnson, James B.	Greencastle	Putnam	Karnafel, Eugene T.	Madison	Jefferson- Switzerland
Johnson, Jerome M.	Palmyra	Harrison- Crawford	Karns, John D.	Winamac	Pulaski
Johnson, John J.	Dixon, Ill.	Kosciusko	Karol, Herbert J.	Fort Wayne	Allen
Johnson, Lonnie B.	Gary	Lake	Karpel, Bernard	Mooreville	Morgan
Johnson, Lowell R.	Lafayette	Tippecanoe	Karsell, William A.	Bloomington	Owen-Monroe
Johnson, Paul D.	Terre Haute	Vigo	Kasting, Gerald	Bedford	Lawrence
Johnson, Robert B.	Hope	Bartholomew- Brown	Katterjohn, James C.	Indianapolis	Marion
Johnson, Stephen L.	Evansville	Vanderburgh	Kauffman, Harley M.	Indianapolis	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion	Kauffman, Nelson N.	Indianapolis	Marion
Johnson, William A. (S)	Perrysville	Parke- Vermillion	Kaufman, Julian	Fort Wayne	Allen
Johnson, William A.	North Vernon	Jennings	Kaufman, Lillie S.	Goshen	Elkhart
Johnson, William H.	Indianapolis	Marion	Kay, Oran E.	Spencer	Owen-Monroe
Johnston, Alan	Martinsville	Morgan	Keating, John U.	Elkhart	Elkhart
Johnston, Donald D. (S)	Westville	La Porte	Keck, Carleton A.	Fort Wayne	Allen
Johnston, Richard M.	Warsaw	Kosciusko	Keeling, Forrest E.	Portland	Jay
Johnston, Robert G. (S)	Huntington	Huntington	Keenan, George B.	Indianapolis	Marion
Jolly, Lewis E.	Madison	Jefferson- Switzerland	Keenan, Reid L.	Indianapolis	Marion
Jolly, Wesley P. (S)	Richland	Spencer	Keever, Charles H.	Indianapolis	Marion
Jones, Albert T.	Anderson	Madison	Keiser, Venice D.	Indianapolis	Marion
Jones, Allen W.	Indianapolis	Marion	Kellar, Philip E.	Hobart	Lake
Jones, Charles A.	Franklin	Johnson	Keller, Frank G. (S)	N. Manchester	Wabash
Jones, David	Lafayette	Tippecanoe	Kelly, Don E.	Indianapolis	Marion
Jones, David E.	Indianapolis	Marion	Kelly, Frank (S)	Argos	Marshall
Jones, David G.	Anderson	Madison	Kelly, John B.	Evansville	Vanderburgh
Jones, David H.	Charlestown	Clark	Kelly, Wendell C.	Anderson	Madison
Jones, Edwin F.	Rensselaer	Jasper- Newton	Kelsey, Lawrence E.	Kewanna	Fulton
Jones, Eli S.	Hammond	Lake	Kelsey, Robert M., Jr.	La Porte	La Porte
Jones, Francis P.	Indianapolis	Marion	Kelsey, Robert M., Sr.	La Porte	La Porte
Jones, George L.	Wanamaker	Marion	Kemker, Bernard P.	Tell City	Perry
Jones, Gordon C.	Indianapolis	Marion	Kemp, John T.	Michigan City	La Porte
Jones, Horace E.	Anderson	Madison	Kemp, William A.	Connerville	Fayette- Franklin
Jones, J. Carl	Logansport	Cass	Kempf, Gerald F.	Rockville	Parke- Vermillion
Jones, John G. (S)	Vincennes	Knox	Kendall, Forest M.	Nappanee	Elkhart
Jones, King S.	Michigan City	La Porte	Kendrick, Frank J.	Gary	Lake
Jones, Lawrence R.	Indianapolis	Marion	Kennedy, Eva N. (S)	Camden	Carroll
Jones, Roland W.	Bethesda, Md.	Marion	Kennedy, Hunter F.	Indianapolis	Marion
Jontz, Joe G.	Fort Wayne	Allen	Kennedy, Joseph T.	Indianapolis	Marion
Jontz, Richard L.	Indianapolis	Marion	Kennedy, Myron S.	Goshen	Elkhart
Jordan, Leo E.	Lynn	Randolph	Kennedy, Walter U. (S)	New Castle	Henry
Jordan, Richard A.	Corydon	Harrison- Crawford	Kenney, David B.	Indianapolis	Marion
Joseph, Rex M.	Indianapolis	Marion	Kenney, Francis D.	Hammond	Lake
Jowitt, Richard H.	Indianapolis	Marion	Kenoyer, Wilbur L.	Biloxi, Miss.	Marion
Judd, Donald R.	Indianapolis	Marion	Kent, Richard N.	Fort Wayne	Allen
Judson, Walter E.	Indianapolis	Marion	Kenyon, Charles E.	Cambridge City	Wayne-Union
Juergens, Richard B.	Fort Wayne	Allen	Kenzler, Jack	Indianapolis	Marion
Jump, Charles A. (S)	Selma	Delaware- Blackford	Kephart, S. Bruce	Bluffton	Wells
			Kepler, Robert W.	La Porte	La Porte
			Kercheval, John M.	Clinton	Parke- Vermillion

Name	City	County	Name	City	County
Kern, Charles B. (S)	Noblesville	Hamilton	Klos, Stanley J.	Hobart	Lake
Kern, Clarence G.	Lebanon	Boone	Kmak, Chester	Detroit, Mich.	Lake
Kerr, Charlotte H.	Michigan City	La Porte	Knapp, Arthur L. (S)	South Bend	St. Joseph
Kerr, Donald M.	Bedford	Lawrence	Kneidel, John H.	Indianapolis	Marion
Kerr, Harry R.	Indianapolis	Marion	Knight, Lewis W.	Fort Wayne	Allen
Kerr, John E.	Michigan City	La Porte	Knodel, Kenneth T.	South Bend	St. Joseph
Kerrigan, John F.	Michigan City	La Porte	Knotts, Halleck S.	Columbus	Bartholomew-
Kerrigan, Robert L. (S)	Michigan City	La Porte			Brown
Kerrigan, William F.	Connersville	Fayette-Franklin	Knotts, Slater	Columbus	Bartholomew-
					Brown
Keseric, N. E.	French Lick Springs	Orange	Knowles, Charles Y.	Indianapolis	Marion
Kesim, Mufti	Elkhart	Elkhart	Knowles, Robert P.	Indianapolis	Marion
Kessler, Robert B.	Evansville	Vanderburgh	Ko, Richard	Gaston	Delaware-
Ketcham, Jane M. (S)	Indianapolis	Marion			Blackford
Ketcham, John S. (S)	Rossville	Clinton	Kobrin, Meyer W.	Gary	Lake
Keyes, Robert C.	Fort Wayne	Allen	Koch, Edwin F. Jr.	Indianapolis	Marion
Khaton, Odessa M.	Gary	Lake	Koch, Elmer L.	Danville	Hendricks
Kidd, James G. (S)	Wood, Wis.	Wabash	Koch, Howard W.	Winchester	Randolph
Kidder, Orva T.	Fort Wayne	Allen	Koehler, Elmer G.	Elkhart	Elkhart
Kiechle, Frederick L.	Evansville	Vanderburgh	Koenig, Robert L.	Valparaiso	Porter
Kiely, John T.	Anderson	Madison	Kohlstaedt, Karl C.	Indianapolis	Marion
Kilgore, Byron W.	Topeka, Kan.	Marion	Kohlstaedt, Kenneth G.	Indianapolis	Marion
Kilmer, Warren L.	Gary	Lake	Kohne, Gerald J.	Decatur	Adams
Kim, Young D.	Beech Grove	Marion	Kohne, Robert W.	Lafayette	Tippecanoe
Kimbrough, Robert F.	Fort Wayne	Allen	Kolanko, Leon A.	Hammond	Lake
Kime, Charles E.	Richmond	Wayne-Union	Kolettis, John G.	Gary	Lake
Kime, Edwin N.	Indianapolis	Marion	Komoroske, John E.	East Chicago	Lake
Kimmel, George E.	Camp LeJeune, N. C.	Miami	Kooiker, John E.	Indianapolis	Marion
			Koons, Karl M.	Indianapolis	Marion
Kincaid, Raymond K.	Tipton	Tipton	Koontz, William A.	Gas City	Grant
Kincaid, Robert S.	Evansville	Vanderburgh	Kopanko, Bernard F.	East Chicago	Lake
Kindell, Hurschell D.	New Richmond	Montgomery	Kopcha, Joseph E.	Gary	Lake
			Kopecky, Robert R.	Indianapolis	Marion
King, Harold	Indianapolis	Marion	Kopp, Otis A.	Anderson	Madison
King, Jay M.	Logansport	Cass	Kopp, William R.	Anderson	Madison
King, Joseph W.	Anderson	Madison	Koransky, David S.	Hammond	Lake
King, Robert W.	Cedar Lake	Lake	Korn, Jerome M.	Gary	Lake
King, William E.	Indianapolis	Marion	Kornafel, L. H.	Indianapolis	Marion
Kingsbury, John K. (S)	Indianapolis	Marion	Koss, K. William	Muncie	Delaware-
Kinnaman, Howard A.	Crawfordsville	Montgomery			Blackford
Kinneman, Robert E.	Greenfield	Hancock	Krabill, Willard S.	Goshen	Elkhart
Kintner, Burton E.	Elkhart	Elkhart	Kraft, Bennett	Indianapolis	Marion
Kinzel, Robert J. W.	Indianapolis	Marion	Kraft, Haldon C.	Noblesville	Hamilton
Kirby, Ted C.	Greenfield	Hancock	Kraning, Kenneth K.	Kewanna	Fulton
Kirkhoff, Paul J.	Indianapolis	Marion	Krause, Friedrich	Elkhart	Elkhart
Kirklin, Oren L.	Indianapolis	Marion	Kreitl, Dorothy R.	Richmond	Wayne-Union
Kirshman, Forrest E.	Muncie	Delaware-Blackford	Kremers, George A.	Kokomo	Howard
			Kresler, Leon E.	Kentland	Jasper-Newton
Kirtley, James M.	Crawfordsville	Montgomery	Kress, James W.	Muncie	Delaware-Blackford
Kirtley, Robert W.	Danville	Hendricks			
Kirtley, William R.	Indianapolis	Marion	Kriebel, William W.	Terre Haute	Vigo
Kissel, Wesley A.	Indianapolis	Marion	Kriel, William B.	Indianapolis	Marion
Kissinger, Knight L.	Angola	Steuben	Krsek, Archie J.	Hobart	Lake
Kistler, James J.	La Porte	La Porte	Krueger, John E.	Fort Wayne	Allen
Kistner, Arthur W.	Elkhart	Elkhart	Krueger, John E.	South Bend	St. Joseph
Kitterman, Harry E.	Indianapolis	Marion	Krueger, Robert B.	Columbus	Bartholomew-
Klain, Benjamin V.	Indianapolis	Marion			Brown
Klamer, Charles H.	Jasper	Dubois	Kruse, Edward H. (S)	Fort Wayne	Allen
Klatch, Ben Z.	Lafayette	Tippecanoe	Kruse, Walter E.	Fort Wayne	Allen
Klatte, Eugene C.	Indianapolis	Marion	Kubik, Francis J.	Michigan City	La Porte
Klaus, Julius M.	Gary	Lake	Kuble, James D.	Plymouth	Marshall
Kleifgen, William A.	Fort Wayne	Allen	Kudele, Louis T.	Whiting	Lake
Klein, Emanuel	Indianapolis	Marion	Kuhn, Arthur J.	Hammond	Lake
Kleindorfer, Roscoe L.	Evansville	Vanderburgh	Kuhn, Frederick L.	South Bend	St. Joseph
Kleinman, Francis J. (S)	Hebron	Porter	Kuhn, Hedwig S.	Hammond	Lake
Kleopfer, Ronald G.	Indianapolis	Marion	Kuhn, Robert W.	Wilkinson	Hancock
Klepfer, Jefferson F.	Richmond	Wayne-Union	Kunkler, Arnold W.	Terre Haute	Vigo
Klepinger, Carol A.	Indianapolis	Marion	Kunkler, Joseph (S)	Terre Haute	Vigo
Klepinger, Harry E.	Lafayette	Tippecanoe	Kunkler, William C.	Terre Haute	Vigo
Kline, Charles D.	Vincennes	Knox	Kuntz, Herman W.	Indianapolis	Marion
Klooze, Kenneth W.	Fort Wayne	Allen	Kunz, Albert L.	Greenwood	Johnson
			Kurlander, Gerald J.	Indianapolis	Marion
			Kurtz, Fred B. (S)	Indianapolis	Marion
			Kurtz, Philip L.	Indianapolis	Marion
			Kurtz, Richard	Chicago, Ill.	Marion
			Kurtz, William A.	Tipton	Tipton
			Kwitny, Isadore J.	Indianapolis	Marion
			Kyle, Michael A.	Indianapolis	Marion

Name	City	County	Name	City	County
L					
LaBier, Clarence R. (S)	Terre Haute	Vigo	Leibundguth, Henry	Evansville	Vanderburgh
Lacy, John D., Jr.	Medaryville	Pulaski	Leich, Charles F.	Evansville	Vanderburgh
Ladig, Donald S.	Fort Wayne	Allen	Leinbach, Earl	Hamlet	Starke
LaDine, Clarence B.	Indianapolis	Marion	LeMaster, Theodore R.	Indianapolis	Marion
LaFollette, Donald	New Albany	Floyd	Leming, Ben L.	Fort Wayne	Allen
LaFollette, Forrest R.	Hammond	Lake	Lenk, George G.	Fort Wayne	Allen
LaFollette, Robert E.	New Albany	Floyd	Lenox, Jack	Lebanon	Boone
Lahr, Richard E.	Marion	Grant	Leonard, Henry S. (S)	Indianapolis	Marion
Lalonde, Alban H.	Indianapolis	Marion	Leroy, Alvin G.	Alexandria	Madison
Lamb, Emmett B.	Indianapolis	Marion	Leser, Ralph U.	Indianapolis	Marion
Lamb, J. Leonard	South Bend	St. Joseph	Lester, Vern L.	South Bend	St. Joseph
Lamb, Russell W.	Indianapolis	Marion	Lett, Emory B.	Loogootee	Daviess-Martin
Lamber, Chet K.	Indianapolis	Marion			
Lambert, Ross W.	Camp Pendleton, Calif.	Marion	Levatin, Bernard I.	South Bend	St. Joseph
Lamey, James L.	Anderson	Madison	Levering, Guy P. (S)	Lafayette	Tippecanoe
Lamey, Paul T.	Anderson	Madison	Levi, Leon	Indianapolis	Marion
Lampe, Elfred H.	Fort Wayne	Allen	Levin, Eli L.	East Chicago	Lake
Lancet, Robert O.	Terre Haute	Vigo	Levin, Ralph T.	Indianapolis	Marion
Land, Francis L.	Fort Wayne	Allen	Levkoff, Abner H.	South Bend	St. Joseph
Land, Richard N.	Anderson	Madison	Lewis, Earl T.	Evansville	Vanderburgh
Landis, Charles B.	Lafayette	Tippecanoe	Lewis, George N.	Gary	Lake
Landon, David J.	Union City	Randolph	Lewis, James F.	Liberty	Wayne-Union
Lands, Robert M.	Indianapolis	Marion	Lewis, Lucien A.	Gary	Lake
Landwehr, Alfons	Indianapolis	Marion	Lewis, Paul S.	Indianapolis	Marion
Lane, Charlotte E.	Indianapolis	Marion	Lewis, R. Earl	Indianapolis	Marion
Lane, William H.	South Bend	St. Joseph	Lewis, Robert J.	Lawrence	Marion
Lang, Erich K.	Indianapolis	Marion	Lichtenberg, Melvin	Indianapolis	Marion
Lang, Joseph E.	South Bend	St. Joseph	Liddell, Charles K.	Michigan City	La Porte
Langdon, Harry K. (S)	Indianapolis	Marion	Lidikay, Edward C.	Indianapolis	Marion
Langohr, John	Columbia City	Whitley	Life, Homer L.	New Castle	Henry
Langrall, Harrison M., Jr.	Marion	Grant	Lind, Jaap J.	Mulberry	Clinton
Lanman, John U.	Munster	Lake	Lindenborg, Paul G.	Indianapolis	Marion
Lanning, R. Adrian	Noblesville	Hamilton	Lindsay, Hamlin B.	Washington	Daviess-Martin
Lansford, Kenneth G.	Indianapolis	Marion			
Laramore, Ward	Indianapolis	Marion	Ling, John F.	Richmond	Wayne-Union
Larmore, Joseph L.	Anderson	Madison	Lingeman, Byron N.	Crawfordsville	Montgomery
Larmore, Sarah H.	Anderson	Madison	Lingeman, Raleigh E.	Indianapolis	Marion
Larrabee, James F.	Munster	Lake	Lingeman, Roger E.	Indianapolis	Marion
Larson, George E.	Marion	Grant	Link, Goethe (S)	Indianapolis	Marion
Larson, Goyt O.	La Porte	La Porte	Link, William C.	Bloomington	Owen-Monroe
LaSalle, Richard M.	Wabash	Wabash	Lionberger, John R.	South Bend	St. Joseph
LaSalle, Robert M., Jr.	Wabash	Wabash	Lippoldt, Charles L.	Oldenburg	Ripley
LaSalle, Robert M., Sr.	Wabash	Wabash	Lipschutz, Harold	Gary	Lake
Lasich, Anthony R.	Indianapolis	Marion	Lipsey, Alfred J.	Gary	Lake
Laubscher, Clarence	Evansville	Vanderburgh	Liss, Emanuel C.	Forest Hills, N. Y.	St. Joseph
Laudeman, Walter A.	Elwood	Madison			
Lauer, Dorothy B.	Dana	Parke-Vermillion	Little, John W. (S)	Decatur, Ill.	Marion
			Littlefield, Paul A.	Indianapolis	Marion
Lautz, Herbert A.	Hammond	Lake	Littlefield, Shirley	Indianapolis	Marion
Lavengood, Russell W.	Marion	Grant	Litzenberger, Sam W.	Anderson	Madison
Lawler, George F.	Indianapolis	Marion	Llamas, Dominador F.	North Judson	Starke
Lawrence, Joseph C.	Evansville	Vanderburgh	Lloyd, Frank P.	Indianapolis	Marion
Laws, Kenneth F.	Lafayette	Tippecanoe	Lloyd, Joe R.	Noblesville	Hamilton
Lawson, Isaac H. (S)	Kendallville	Noble	Lloyd, Robert P.	Fort Wayne	Allen
Laycock, Richard M.	Fort Wayne	Allen	Lochry, Ralph L. (S)	Indianapolis	Marion
Layman, Douglas C.	Indianapolis	Marion	Lockhart, Jack M.	Connersville	Fayette-Franklin
Lazo, Vicente R.	Gary	Lake			
Leahy, Howard J.	Pendleton	Madison	Lockhart, Philip B.	South Bend	St. Joseph
Leak, Robert H.	Boswell	Benton	Loehr, William M.	Indianapolis	Marion
Leasure, J. Kent	Indianapolis	Marion	Loewenstein, Werner L.	Terre Haute	Vigo
Leatherman, Harter L.	Indianapolis	Marion	Logan, James Z.	Richmond	Wayne-Union
Lebioda, Henry S.	Gary	Lake	Logan, Richard S.	Fort Wayne	Allen
Lee, Glen Ward	Richmond	Wayne-Union	Lohman, Robert M.	Fort Wayne	Allen
Lee, James	Terre Haute	Vigo	Lohoff, Lewis C.	Tell City	Perry
Lee, John M. (S)	Rushville	Rush	Loh, Hwei Ya (Chang)	Gary	Lake
Lee, Robert Y.	Valparaiso	Porter	Loh, Wei-Ping	Gary	Lake
Leffel, James M.	Indianapolis	Marion	Long, Keith J.	Hammond	Lake
Leffler, William T.	Indianapolis	Marion	Long, Malcolm D.	Indianapolis	Marion
Lehman, Emery W.	Bluffton	Wells	Long, Max R.	Marion	Grant
Lehman, Kenneth M.	Topeka	LaGrange	Long, Paul L.	Anderson	Madison
Lehmberg, Otto F. C.	Columbia City	Whitley	Lonngren, Dudley H.	Marion	Grant
			Loomis, Charles H.	Richmond	Wayne-Union
			Loomis, Norman S.	Indianapolis	Marion
			Loop, Frederick A.	Lafayette	Tippecanoe
			Lord, Glen C.	Indianapolis	Marion
			Lorenty, Thaddeus B.	Gary	Lake
			Lorman, James G.	Fort Wayne	Allen

Name	City	County	Name	City	County
Louden, Robert W.	Indianapolis	Marion	Mann, Richard E.	Indianapolis	Marion
Loudermilk, Jack L.	Fort Wayne	Allen	Manner, Richard J.	Evansville	Vanderburgh
Loughlin, Lawrence L.	Indianapolis	Marion	Manning, George C.	Fort Wayne	Allen
Love, George N.	Indianapolis	Marion	Manning, K. Randolph	Indianapolis	Marion
Love, V. Logan	Marion	Grant	Manship, Stanley	Paoli	Orange
Lovell, Martin H.	Gary	Lake	Mansueto, Mario D.	Hammond	Lake
Lovett, Harvey D.	Whitestown	Boone	Manzanero, Fortunato M.	Bedford	Lawrence
Loving, Jury B.	New Goshen	Vigo	Manzie, Michael W.	Indianapolis	Marion
Lowery, George E.	New Castle	Henry	Maple, James B. (S)	Sullivan	Sullivan
Lozow, David	Indianapolis	Marion	Marchand, Edwin V.	Haubstadt	Gibson
Lucas, Clarence A., Jr.	Indianapolis	Marion	Marchand, John H., Jr.	Evansville	Vanderburgh
Luckett, Coen L.	Terre Haute	Vigo	Marchant, Clarence H.	Bloomington	Owen-Monroe
Luckey, Robert C.	Wolf Lake	Noble	Marcus, Emanuel	Hammond	Lake
Luginbill, Howard M.	Berne	Adams	Marcus, Morris C.	Gary	Lake
Lukemeyer, George T.	Indianapolis	Marion	Maris, Lee J.	Attica	Fountain-Warren
Lukemeyer, St. John	Jasper	Dubois	Markle, Joseph G.	Hobart	Lake
Lundblad, Wilfred M.	Bloomington	Owen-Monroe	Marks, Howard H.	Huntington	Huntington
Lundeberg, Ralph A.	Griffith	Lake	Marks, Maurice I.	Indianapolis	Marion
Lundt, Milo O.	Elkhart	Elkhart	Marks, Ora L.	East Chicago	Lake
Lunsford, Thomas E.	Indianapolis	Marion	Marks, Salvo P.	Hammond	Lake
Lurie, Paul R.	Indianapolis	Marion	Marquinez, Adoracion	East Chicago	Lake
Luros, J. Theodore	Indianapolis	Marion	Marquis, Gordon	South Bend	St. Joseph
Lutes, David L. (S)	Edinburg	Johnson	Marr, Griffith	Columbus	Bartholomew-Brown
Lutz, Georgianna	Gary	Lake	Marsh, Carl M.	Indianapolis	Marion
Luzadder, John E.	New Carlisle	St. Joseph	Marsh, Chester A. (S)	Los Angeles, Calif.	Henry
Lybrook, Daniel E. (S)	Young	Cass	Marsh, George W.	Lafayette	Tippecanoe
Lybrook, William B.	Indianapolis	Marion	Marsh, Myrle F.	Indianapolis	Marion
Lyman, Frank L.	White Plains, N. Y.	Vanderburgh	Marshall, Albert L., Jr.	Indianapolis	Marion
Lynch, Harold D.	Evansville	Vanderburgh	Marshall, Caesar L.	Fort Wayne	Allen
Lynch, Otis R.	Marengo	Harrison-Crawford	Marshall, Cavins R. (S)	Indianapolis	Marion
Lyon, Florence M.	Portland	Jay	Marshall, George L. (S)	Bourbon	Marshall
Lyon, William C.	Fort Wayne	Allen	Marshall, Lloyd C. (S)	Mt. Summit	Henry
Lyons, L. Mason	Terre Haute	Vigo	Marshall, Millard R.	Gary	Lake
Lyons, Robert E.	Bloomington	Owen-Monroe	Marshall, Thos. J. (S)	Charlestown	Clark
			Marshall, Thomas R.	Charlestown	Clark
M			Marske, Robert L.	Michigan City	La Porte
MacCollum, M. Speers	Indianapolis	Marion	Martin, Charles E. (S)	Lynn	Randolph
MacDougall, John D.	Indianapolis	Marion	Martin, Charles F.	Mishawaka	St. Joseph
MacKenzie, Pierce	Evansville	Vanderburgh	Martin, Floyd S.	Goshen	Elkhart
MacLeod, Donald F.	W. Lafayette	Tippecanoe	Martin, Guy	Seymour	Jackson
MacLeod, John K.	South Bend	St. Joseph	Martin, Hugh E.	Indianapolis	Marion
Machlett, John H.	Whiteland	Johnson	Martin, Joe M.	Lafayette	Tippecanoe
Mackel, Frederick O.	Fort Wayne	Allen	Martin, Loren H.	Indianapolis	Marion
Mackey, Colonel G. (S)	Logansport	Cass	Martin, Paul H.	Elkhart	Elkhart
Mackey, Harry S. (S)	Indianapolis	Marion	Martin, Samuel W.	Corydon	Harrison-Crawford
Mackey, John E.	Indianapolis	Marion	Martz, Bill L.	Indianapolis	Marion
Macy, George W.	Columbus	Bartholomew-Brown	Martz, Carl D.	Indianapolis	Marion
Madlang, R. M.	Munster	Lake	Marvel, Howard R.	Lafayette	Tippecanoe
Madden, Robert J.	Indianapolis	Marion	Marvel, James A.	Evansville	Vanderburgh
Mader, John H.	Richmond	Wayne-Union	Marvel, Robert J.	Indianapolis	Marion
Madston, A. Ricks	Indianapolis	Marion	Maschmeyer, Robert H.	Logansport	Cass
Magennis, Herbert L. (S)	Indianapolis	Marion	Mason, Bernard A.	South Bend	St. Joseph
Mahaffey, John E.	Indianapolis	Marion	Mason, Donald G.	Angola	Steuben
Mahank, Camiel C.	Mishawaka	St. Joseph	Mason, Everett E.	Evansville	Vanderburgh
Mahoney, Charles L.	Terre Haute	Vigo	Mason, John C.	Hammond	Lake
Majsterek, Stanley L.	Gary	Lake	Mason, Lester M.	Terre Haute	Vigo
Makovsky, Theodore	Valparaiso	Porter	Mason, Richard L.	Hammond	Lake
Malcolm, Russell L., Jr.	Indianapolis	Marion	Massanari, Walter	Millersburg	Elkhart
Malcolm, Russell L.	Richmond	Wayne-Union	Masters, John M.	Indianapolis	Marion
Malone, Leander A.	Terre Haute	Vigo	Masters, Robert J.	Indianapolis	Marion
Malott, Fred R.	Converse	Miami	Mastrangelo, M. J.	Fort Wayne	Allen
Malouf, Stephen D. (S)	Peru	Miami	Mather, Charles R.	Lafayette	Tippecanoe
Manalan, Maurice M.	Indianapolis	Marion	Mather, J. Winford	East Gary	Lake
Manalo, Francisco M.	Gary	Lake	Mather, Robert L.	Lafayette	Tippecanoe
Manders, Karl L.	Indianapolis	Marion	Mathews, James R.	Evansville	Vanderburgh
Manhart, Doyle B.	Indianapolis	Marion	Mathewson, Russell C.	Muncie	Delaware-Blackford
Manifold, Harold M.	Bloomington	Owen-Monroe	Mathys, Alfred (S)	Mauckport	Harrison-Crawford
Manion, Marlow W.	Indianapolis	Marion			
Mankin, William J.	Terre Haute	Vigo			
Mann, Mortimer	Indianapolis	Marion			

Name	City	County	Name	City	County
Matthew, John R.	Westville	La Porte	McDonald, Virgil G. (S)	Anderson	Madison
Matthew, W. Burleigh	Indianapolis	Marion	McDowell, Fletcher W.	Muncie	Delaware-Blackford
Matthews, Bernard J.	Indianapolis	Marion	McDowell, George A.	Fort Wayne	Allen
Matthews, Dennis W. (S)	North Vernon	Jennings	McDowell, Mordecai M.	Vincennes	Knox
Matthews, William M.	Indianapolis	Marion	McEachern, Cecil G.	Fort Wayne	Allen
Mattmiller, Everette D.	Avilla	Noble	McElroy, James S.	New Castle	Henry
Mattox, Don M.	Terre Haute	Vigo	McElroy, Robert S.	Princeton	Gibson
Matzen, Richard N.	Bluffton	Wells	McEwen, James W.	Terre Haute	Vigo
Maurer, J. Frank	Brazil	Clay	McFadden, James M.	Lafayette	Tippecanoe
Maurer, Robert M.	Brazil	Clay	McFarland, Corley B.	South Bend	St. Joseph
Mauzy, Merritt C.	South Bend	St. Joseph	McGee, Robert R.	New Castle	Henry
Maxam, B. T.	Indianapolis	Marion	McGrath, Michael F.	Indianapolis	Marion
Maxson, Roy V.	Evansville	Vanderburgh	McGue, Frank J.	Michigan City	La Porte
May, George A.	Madison	Jefferson-Switzerland	McGuff, Paul E.	Indianapolis	Marion
May, Richard M.	Gary	Lake	McGuire, D. F. (S)	East Chicago	Lake
May, William D.	New Albany	Floyd	McIlwain, Eleanor E.	Warren	Huntington
Mayberry, Alton	Evansville	Vanderburgh	McIlwain, Robert E.	Warren	Huntington
Mayes, Warren E.	Oakland, Calif.	Allen	McIndoo, Ralph E. (S)	Kokomo	Howard
Mayfield, Clifford H. (S)	Reynolds	White	McIntire, Clarence R.	Bloomington	Owen-Monroe
McAdams, Hugh B.	Lafayette	Tippecanoe	McIntosh, Wilbert	Riley	Vigo
McAdams, Robert	Lafayette	Tippecanoe	McIntyre, Charles J. (S)	Indianapolis	Marion
McAleese, George B.	Terre Haute	Vigo	McIntyre, James M.	Indianapolis	Marion
McArdle, Edward G.	Fort Wayne	Allen	McKee, Harry G.	Rushville	Rush
McAree, Francis E.	Indianapolis	Marion	McKee, Roy G.	New Castle	Henry
McArt, Bruce A.	Elkhart	Elkhart	McKeeman, Donald H.	Fort Wayne	Allen
McAtee, Ott B.	Madison	Jefferson-Switzerland	McKeeman, Leland S.	Fort Wayne	Allen
McBride, James S.	Indianapolis	Marion	McKeon, Edward C.	Evansville	Vanderburgh
McBride, Noel S.	Terre Haute	Vigo	McKinley, A. David	Indianapolis	Marion
McCabe, James E. (S)	W. Lafayette	Tippecanoe	McKinley, Joseph	Lafayette	Tippecanoe
McCalla, Charles X.	Paoli	Orange	McKinney, Daniel H.	Lafayette	Tippecanoe
McCallister, John W.	Fort Wayne	Allen	McKittrick, Jack	Washington	Daviess-Martin
McCallum, Donald C.	Indianapolis	Marion	McLain, Clarence R., Jr.	Indianapolis	Marion
McCallum, Joseph T. C. (S)	Indianapolis	Marion	McLaren, Daniel E.	Indianapolis	Marion
McCallum, Robert N.	Columbia, S. C.	Marion	McLaughlin, Calvin P.	Pendleton	Madison
McCarthy, Jeremiah A.	Whiting	Lake	McLaughlin, Gordon C.	Terre Haute	Vigo
McCartney, Donald H.	Indianapolis	Marion	McLaughlin, James R.	Flora	Carroll
McCarty, Virgil	Princeton	Gibson	McLean, James S.	Munster	Lake
McClain, Edwin S.	Indianapolis	Marion	McMahan, Virgil C.	Vincennes	Knox
McClain, Marvin L.	Scottsburg	Scott	McMath, Samuel B.	Gary	Lake
McClelland, Donald C. (S)	Lafayette	Tippecanoe	McMeel, James	South Bend	St. Joseph
McClelland, Harry N.	Alexandria	Madison	McMichael, Frank J. (S)	Hernando, Fla.	Lake
McClintock, James A.	Muncie	Delaware-Blackford	McMillan, Frederick G. (S)	Indianapolis	Marion
McClure, Clark	Knox	Starke	McNabb, George B.	Carthage	Rush
McClure, Glenn	Sullivan	Sullivan	McNabb, Richard C.	Carthage	Rush
McClure, Morris E.	Union City	Randolph	McNaughton, Lawrence	Washington	Daviess-Martin
McClure, Stanley E.	Monon	White	McNeely, Matthew J.	Dillsboro	Dearborn-Ohio
McClure, Warren N.	Kokomo	Howard	McQuiston, Ralph J.	Indianapolis	Marion
McConnell, William C.	Sunman	Ripley	McTurnan, Robert W.	Indianapolis	Marion
McCool, Joseph H.	Evansville	Vanderburgh	McVey, Clarence A.	Hammond	Lake
McCord, Carl B. (S)	Veedersburg	Fountain-Warren	McWilliams, William B.	Liberty	Wayne-Union
McCormack, Lloyd L.	Fremont	Steuben	Mead, Clarence H. (S)	Bluffton	Wells
McCormick, Charles O., Jr.	Indianapolis	Marion	Mead, Frank E.	La Porte	La Porte
McCormick, Hubert D. (S)	Vincennes	Knox	Meade, Walter W.	Bicknell	Knox
McCoy, George E.	Muncie	Delaware-Blackford	Mealey, John, Jr.	Indianapolis	Marion
McCoy, Melvin H.	Evansville	Vanderburgh	Medcalf, Norman L. (S)	Lamar	Spencer
McCoy, Roy R.	Fort Wayne	Allen	Megenhardt, Dennis S.	Indianapolis	Marion
McCraley, William J.	South Bend	St. Joseph	Mehne, Richard G.	Brazil	Clay
McCrea, Fred R.	Terre Haute	Vigo	Meier, Donald W.	Bluffton	Wells
McCullough, Henry G.	Columbus	Bartholomew-Brown	Meikle, Louise J. (S)	W. Lafayette	Tippecanoe
McCullough, James Y.	New Albany	Floyd	Meiks, Lyman T.	Indianapolis	Marion
McDaniel, Franklin P. (S)	Atlanta	Hamilton	Meiser, Robert D.	Huntington	Huntington
McDonald, Frank C.	New Castle	Henry	Meister, Doris (S)	Anderson	Madison
McDonald, Joseph D.	Evansville	Vanderburgh	Melin, John R.	Indianapolis	Marion
McDonald, Ralph M.	South Bend	St. Joseph	Mella, Ramon E.	East Chicago	Lake
			Melloh, Ardis F.	Indianapolis	Marion
			Mendelson, Stanley M.	Kokomo	Howard
			Mendez, Carlos	Elkhart	Elkhart
			Mensch, James R.	Fort Wayne	Allen
			Mentendiek, Maurice H.	Indianapolis	Marion
			Mercer, Samuel R.	Fort Wayne	Allen
			Meredith, Elwood J.	Richmond	Wayne-Union
			Mericle, Earl W.	Indianapolis	Marion

Name	City	County	Name	City	County
Merrell, Basil M.	Rockville	Parke-Vermillion	Miofsky, William E.	Indianapolis	Marion
Merrell, Paul	Indianapolis	Marion	Misch, William	Cedar Lake	Lake
Mershon, Jack B.	Indianapolis	Marion	Mishkin, Irving	Elkhart	Elkhart
Mertz, Henry O. (S)	Nokomis, Fla.	Marion	Mishler, Joe B.	Pierceton	Kosciusko
Mertz, John H. O.	Indianapolis	Marion	Mitchell, Edward O.	Indianapolis	Marion
Messer, Frank W.	Kendallville	Noble	Mitchell, George H.	Indianapolis	Marion
Metcalfe, Grant E.	South Bend	St. Joseph	Mitchell, George L. (S)	Smithville	Owen-Monroe
Meyer, Hans	Westville	La Porte	Mitchell, Georgia B.	Gary	Lake
Meyer, Herman A.	Fort Wayne	Allen	Mitman, Floyd B.	Huntington	Huntington
Meyer, Theodore O.	Fort Wayne	Allen	Mittleman, Edwin J.	Ashley	Steuben
Meyn, Werner P.	Terre Haute	Vigo	Moats, Carl F.	Fort Wayne	Allen
Michael, Isaac E.	Indianapolis	Marion	Moats, George E. (S)	Fort Wayne	Allen
Michael, Robert L.	Kokomo	Howard	Mock, Harry E., Jr.	Franklin	Johnson
Michaelis, Stephen C.	Fort Wayne	Allen	Modisett, Jackson W.	Madison	Jefferson-Switzerland
Middleton, Harvey N.	Indianapolis	Marion	Modisett, Marcella S.	Madison	Jefferson-Switzerland
Middleton, Ramona J.	Elkhart	Elkhart	Modjeski, Joseph R.	Hammond	Lake
Middleton, Thomas O.	Bloomington	Owen-Monroe	Moehlenkamp, Chas. E.	Evansville	Vanderburgh
Mikan, V. Robert	Logansport	Cass	Moeller, Victor C.	Fort Wayne	Allen
Miklozek, John E.	Terre Haute	Vigo	Moenning John E.	Indianapolis	Marion
Milan, Joseph F.	Bloomington	Owen-Monroe	Moenning, Walter P.	Indianapolis	Marion
Milan, Shisachki D.	East Chicago	Lake	Moheban, Joseph	Shelbyville	Shelby
Miller, Arthur H. (S)	Russiaville	Howard	Mohler, Floyd W.	Columbus	Bartholomew-Brown
Miller, Dan T. (S)	Fowler	Benton	Molengraft, Cornelius J.	Gary	Lake
Miller, Donald C.	Cedar Lake	Lake	Moleski, Walter L.	East Chicago	Lake
Miller, Donald G.	Middlebury	Elkhart	Molloy, William J. (S)	Muncie	Delaware-Blackford
Miller, Edward D.	Fort Wayne	Allen	Monar, Michael	Rockport	Spencer
Miller, Frank H.	Indianapolis	Marion	Moneyhun, James E.	Anderson	Madison
Miller, Galen R.	Elkhart	Elkhart	Monroe, F. Bruce	Crown Point	Lake
Miller, H. Allison	Marion	Grant	Montes, Herminio Y.	Hammond	Lake
Miller, H. Paul	Fort Wayne	Allen	Montgomery, Lall G.	Muncie	Delaware-Blackford
Miller, Harold E.	Seymour	Jackson	Montgomery, Samuel B. (S)	Cynthiana	Posey
Miller, Harold L.	Richmond	Wayne-Union	Montgomery, William F.	Indianapolis	Marion
Miller, Henderson L. (S)	West Baden Springs	Orange	Moon, Charles E.	Center Point	Clay
Miller, Hugh A.	Elkhart	Elkhart	Moore, Donald F.	Indianapolis	Marion
Miller, James C.	Greensburg	Decatur	Moore, Edwin G.	Gary	Lake
Miller, Jerry A.	LaGrange	LaGrange	Moore, Elwin J.	Indianapolis	Marion
Miller, Jerry R.	Indianapolis	Marion	Moore, Harold T.	Indianapolis	Marion
Miller, John D.	Indianapolis	Marion	Moore, Martha	Madison	Jefferson-Switzerland
Miller, John M.	Indianapolis	Marion	Moore, Richard B.	St. Paul, Minn.	Marion
Miller, John M.	Bloomington	Owen-Monroe	Moore, Robert G.	Vincennes	Knox
Miller, Joseph A.	Oaklandon	Marion	Moore, Thomas C.	Muncie	Delaware-Blackford
Miller, Kenneth D.	Woodburn	Allen	Moore, Will C. (S)	Muncie	Delaware-Blackford
Miller, LaVerne B.	Evansville	Vanderburgh	Moore, William G.	Indianapolis	Marion
Miller, Mahlon F.	Fort Wayne	Allen	Moosey, Louis	Union Mills	La Porte
Miller, Maurice	Michigan City	La Porte	Moran, Mark M. (S)	Portland	Jay
Miller, Milton J.	Evansville	Vanderburgh	Moravec, Arthur E.	Fort Wayne	Allen
Miller, Milo K. (S)	South Bend	St. Joseph	Morchan, Samuel	Indianapolis	Marion
Miller, Orval J.	Fort Wayne	Allen	Morey, Edwin E.	Fort Wayne	Allen
Miller, Raleigh S.	Indianapolis	Marion	Morgan, Margaret E.	Indianapolis	Marion
Miller, Ray D.	Martinsville	Morgan	Moriarty, John R.	Indianapolis	Marion
Miller, Richard C.	Shelbyville	Shelby	Morriscal, Russell J.	Logansport	Cass
Miller, Richard H.	Fort Wayne	Allen	Morris, Hyman R.	Gary	Lake
Miller, Robert B.	Fort Wayne	Allen	Morris, Jean W.	Muncie	Delaware-Blackford
Miller, Robert J.	Poplar, Mont.	Vanderburgh	Morris, Robert A.	Anderson	Madison
Miller, Roland E.	Lafayette	Tippecanoe	Morris, Warren V.	Monticello	White
Miller, Roscoe E.	Indianapolis	Marion	Morrison, George G.	Portland	Jay
Miller, Samuel T. (S)	Elkhart	Elkhart	Morrison, George G., Jr.	Lawrenceburg	Dearborn-Ohio
Miller, Virgil C.	Akron	Fulton	Morrison, James T.	Greensburg	Decatur
Miller, Wayne S.	Flint, Mich.	Huntington	Morrison, Lewis E.	Indianapolis	Marion
Miller, William A.	Hagerstown	Wayne-Union	Morrison, William R.	Kokomo	Howard
Miller, William J.	Fort Wayne	Allen	Morrow, Dean H.	Bethesda, Md.	Marion
Milleson, Ann L. M.	Terre Haute	Vigo	Morrow, Robert J.	Bedford	Lawrence
Millis, Arthur B.	Richmond	Wayne-Union	Mortenson, Leland J.	Fort Wayne	Allen
Millis, Samuel C.	Crawfordsville	Montgomery	Morton, David P.	Westville	La Porte
Mills, Fred E.	Evansville	Vanderburgh			
Mills, John F.	Wabash	Wabash			
Milne, Walter S.	Michigan City	La Porte			
Milos, Robert J.	Gary	Lake			
Milroy, Robert A.	Bluffton	Wells			
Minczewski, Richard C.	Gary	Lake			
Minick, Linus J.	Churubusco	Whitley			
Mininger, Edward P.	Elkhart	Elkhart			
Mino, Robert A.	Evansville	Vanderburgh			
Mintz, Alfred M.	Hammond	Lake			

Name	City	County
Morton, Joseph L.	Indianapolis	Marion
Morton, Walter P.	Indianapolis	Marion
Moser, Elmer B. (S)	Windfall	Tipton
Moser, Edward (S)	Woodburn	Allen
Moser, Rollin H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Moss, Bobby L.	Indianapolis	Marion
Moss, Harlan B.	Indianapolis	Marion
Moss, Herschel C.	Indianapolis	Marion
Moss, Mavor J.	Yorktown	Delaware- Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, Mark H. (S)	Indianapolis	Marion
Mott, Cassell A.	South Bend	St. Joseph
Mott, William H.	Gary	Lake
Moulton, Lillian G.	Evansville	Vanderburgh
Mount, Mathias S.	Bloomfield	Greene
Mount, William M.	Lafayette	Tippecanoe
Mountain, Francis B.	Connersville	Fayette- Franklin
Mouser, Robert W.	Indianapolis	Marion
Mudd, Joseph P.	Clarksville	Clark
Muelchi, Adeline F.	Evansville	Vanderburgh
Mullen, James B.	Indianapolis	Marion
Mueller, Edwin C.	LaPorte	LaPorte
Mueller, Hilbert M.	South Bend	St. Joseph
Mueller, Lawrence W.	Fort Wayne	Allen
Mueller, Lillian B. (S)	Indianapolis	Marion
Muhleman, Charles E.	La Porte	La Porte
Muller, Lullus P.	Indianapolis	Marion
Muller, Paul F.	Indianapolis	Marion
Muller, Victor H.	Indianapolis	Marion
Mumford, E. Bishop (S)	Indianapolis	Marion
Murdock, Harvey L.	Fort Wayne	Allen
Murphy, Edward U.	Evansville	Vanderburgh
Murphy, Eugene C.	South Bend	St. Joseph
Murphy, Joseph F.	Lansing, Ill.	Lake
Murphy, Josephine F.	South Bend	St. Joseph
Murphy, Maurice G. (S)	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, James S.	Camarillo, Calif.	Marion
Murray, William E.	New Castle	Henry
Musselman, Glen G.	Terre Haute	Vigo
Musser, A. Wendell	Indianapolis	Marion
Myers, Charles W. (S)	Indianapolis	Marion
Myers, Roy V.	Indianapolis	Marion

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Nagan, Robert F.	Indianapolis	Marion
Napper, Floyd S.	Scottsburg	Scott
Nash, Justin R.	Albion	Noble
Nason, Robert A.	Garrett	De Kalb
Navin, Hugh K.	Fortville	Hancock
Navarre, Vincent J.	Munster	Lake
Nay, Ernest O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Nayyar, Som N.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Lake
Neale, Alfred E.	Anderson	Madison
Nedelkoff, Bogdan	New Albany	Floyd
Need, Louis T.	Indianapolis	Marion
Need, Richard L.	Indianapolis	Marion
Neely, Alonzo S. (S)	Urbana, Ohio	Marion
Neher, John L.	South Bend	St. Joseph
Neidballa, Edward G.	Bristol	Elkhart
Neifert, Noel L.	Tell City	Perry
Nelson, Audrey H.	Memphis, Tenn.	Marion
Nelson, Carl A.	West Lebanon	Fountain- Warren
Nelson, Dudley	Chandler	Warrick
Nelson, F. Dale	South Bend	St. Joseph

Name	City	County
Nelson, Harold E.	Muncie	Delaware- Blackford
Nelson, John W.	Memphis, Tenn.	Marion
Nelson, Raymond E.	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (S)	Evansville	Vanderburgh
Nesbit, Leonard L.	Anderson	Madison
Nester, Henry G.	Indianapolis	Marion
Netherton, Clyde R. (S)	Chalmers	White
Neudorff, Louis G.	Terre Haute	Vigo
Neukamp, Frank H.	Connersville	Fayette- Franklin
Neumann, Kenneth O.	Lafayette	Tippecanoe
Newby, Eugene	Sheridan	Hamilton
Newcomb, William K.	Royal Center	Cass
Newland, Arthur E.	Bedford	Lawrence
Newman, Alvin E.	Evansville	Vanderburgh
Newman, Daniel M.	Indianapolis	Marion
Newsome, C. K.	Evansville	Vanderburgh
Niccum, Warren L.	Columbia City	Whitley
Nicholas, Dennis	Indianapolis	Marion
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Robert J.	Vincennes	Knox
Nicholson, Raymond W.	Evansville	Vanderburgh
Nicosia, John B.	East Chicago	Lake
Nie, Grover M. (S)	Huntington	Huntington
Nie, Louis W.	Indianapolis	Marion
Niedermayer, Alfred J.	Evansville	Vanderburgh
Nigh, Rufus M.	Fairland	Shelby
Niiges, Richard G.	Gary	Lake
Nill, John H.	Fort Wayne	Allen
Nixon, Byron	Farmland	Randolph
Noblitt, James S. (S)	Rockville	Parke- Vermillion
Nodinger, Louis	Hammond	Lake
Noe, William R.	Bedford	Lawrence
Nohl, John M.	Indianapolis	Marion
Nolan, Gerald R.	Fort Wayne	Allen
Nolin, Richard T.	Indianapolis	Marion
Nolt, Ernest V. (S)	Columbia City	Whitley
Nolting, Henry F. (S)	Indianapolis	Marion
Nonte, Leo R.	Evansville	Vanderburgh
Noonan, Leo C.	Gary	Lake
Norman, William H.	Indianapolis	Marion
Norris, Allen A. (S)	Elkhart	Elkhart
Norris, Ernest B.	Culver	Marshall
Norris, Howard L.	Indianapolis	Marion
Norris, Mary Alice	Ft. Sheridan, Ill.	Marion
Norris, Marvin G.	Rushville	Rush
Norris, Max S.	Indianapolis	Marion
Norton, Harold J.	Columbus	Bartholomew- Brown
Norton, Horace O.	Washington	Daviess- Martin
Nourse, Myron H.	Indianapolis	Marion
Noveroske, Richard J.	Indianapolis	Marion
Novy, Charles A.	Garrett	De Kalb
Nugen, Harold	Auburn	De Kalb
Nugen, Margaret Owen	Auburn	De Kalb
Nugent, Edwin J.	Indianapolis	Marion
Nurnberger, John I.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush
O		
Oak, David D., Sr. (S)	LaCrosse	La Porte
Oak, David D., Jr.	Hanna	La Porte
Oatman, Jack G.	Marion	Grant
Oberlander, Seymour	Gary	Lake
O'Brian, Earl J.	Indianapolis	Marion
O'Brian, John F.	Fort Wayne	Allen

Name	City	County	Name	City	County
O'Brien, Francis E.	Rensselaer	Jasper-Newton	Parker, Carey B.	Fort Wayne	Allen
O'Brien, Raymond J.	Michigan City	La Porte	Parker, Carl B.	Wingate	Montgomery
O'Bryan, Richard B.	Columbus	Bartholomew-Brown	Parker, E. Camille	Logansport	Cass
O'Connor, Joseph M.	Muncie	Delaware-Blackford	Parker, Francis W., Jr.	Logansport	Cass
Ochsner, Harold C.	Indianapolis	Marion	Parker, George F., Jr.	Indianapolis	Marion
Ockerman, Kenneth R.	Rensselaer	Jasper-Newton	Parker, Harry C. (S)	Hobart	Lake
Offutt, Andrew C.	Indianapolis	Marion	Parker, John C.	Goodland	Jasper-Newton
Olcott, Charles W.	Aurora	Dearborn-Ohio	Parker, John F.	Indianapolis	Marion
Oldag, George E.	Elwood	Madison	Parker, L. Burton	Orlando, Fla.	Marion
Oliphant, Frank W.	Mount Vernon	Posey	Parker, Portia	Indianapolis	Marion
Oliphant, Robert W.	Terre Haute	Vigo	Parks, George O.	Hartford City	Delaware-Blackford
Olson, Donald T.	South Bend	St. Joseph	Parks, Herbert E.	Indianapolis	Marion
Olson, Kenneth L.	South Bend	St. Joseph	Parmenter, Harry B.	Indianapolis	Marion
Olson, William H.	Michigan City	La Porte	Parr, Robert L.	Indianapolis	Marion
Olvey, Ottis N.	Indianapolis	Marion	Parratt, Louis W.	Gary	Lake
O'Malley, Martha A.	Indianapolis	Marion	Parrish, Richard K.	Decatur	Adams
Omstead, Milton	Petersburg	Pike	Parrot, Donald J.	Fort Wayne	Allen
Omstead, Trevalyn W.	Huntington	Huntington	Parshall, Dale B.	Elkhart	Elkhart
O'Neill, Martin J.	Valparaiso	Porter	Parsons, Robert L.	South Bend	St. Joseph
Onorato, Joseph J.	Lafayette	Tippecanoe	Paskind, J.	Indianapolis	Marion
Onyett, Harold R.	Greenwood	Johnson	Passino, James	Richmond	Wayne-Union
Orders, Clarke E. (S)	Indianapolis	Marion	Pastor, Julius W.	Evansville	Vanderburgh
Oren, William F.	South Bend	St. Joseph	Patrick, Glenn B.	Elkhart	Elkhart
Ormiston, Michael W.	Indianapolis	Marion	Patterson, William K.	Anderson	Madison
Ornelas, Joseph P.	Gary	Lake	Pattison, John D.	Marion	Grant
O'Rourke, Carroll	Fort Wayne	Allen	Paul, Eudell G.	Munster	Lake
Orr, W. Robert	South Bend	St. Joseph	Paul, Leonard G.	Michigan City	La Porte
Oster, Jack H.	Westville	La Porte	Paulin, Burt B.	Indianapolis	Marion
Osterman, Louis H.	Seymour	Jackson	Pauly, Leonard R.	Fort Wayne	Allen
Oswald, Robert H.	Evansville	Vanderburgh	Paulissen, George T.	Indianapolis	Marion
Oswalt, James T.	Mitchell	Lawrence	Pauszek, Thomas B.	South Bend	St. Joseph
Otten, Claude F.	Indianapolis	Marion	Payne, Arthur C.	East Chicago	Lake
Otten, Ralph E.	Darlington	Montgomery	Paynter, Morris B.	Southport	Marion
Overley, Ross A.	Indianapolis	Marion	Paynter, William	Pekin	Washington
Overley, Toner M., Jr.	Indianapolis	Marion	Paz, Luis	Shelbyville	Shelby
Overpeck, Charles	Greensburg	Madison	Peacock, Norman F.	Crawfordsville	Montgomery
Overpeck, George H.	Alexandria	Decatur	Peacock, Robert C.	Muncie	Delaware-Blackford
Overshiner, Lyman (S)	Columbus	Bartholomew-Brown	Pearce, Roy V.	Terre Haute	Vigo
Owen, John E.	Indianapolis	Marion	Pearcy, Marcene	Marion	Grant
Owen, Thomas F.	Alexandria	Madison	Pearlman, Samuel S. (S)	Lafayette	Tippecanoe
Owens, Thomas R.	Muncie	Delaware-Blackford	Pearson, Huey L.	Fort Wayne	Allen
Owens, Tracy C.	Indianapolis	Marion	Pearson, John S.	Indianapolis	Marion
Owsley, Guy A.	Hartford City	Delaware-Blackford	Pearson, Lyman R.	Indianapolis	Marion
Oyer, John H.	Fort Wayne	Allen	Pearson, William E.	Wabash	Wabash
P			Pebworth, Aubrey C. (S)	Indianapolis	Marion
Pace, Jerome V.	Rockville	Parke-Vermillion	Peck, Edward A.	Hammond	Lake
Paff, William A.	Elkhart	Elkhart	Peck, Franklin B., Jr.	Indianapolis	Marion
Pagedas, Tom C.	Indianapolis	Marion	Peck, Franklin B., Sr.	Indianapolis	Marion
Paine, George E.	Elkhart	Elkhart	Peck, James F.	Princeton	Gibson
Painter, Donald S.	Fort Wayne	Allen	Peiffer, Geraldine M.	Hammond	Lake
Painter, Lowell W.	Winchester	Randolph	Peirce, James D.	Indianapolis	Marion
Palmer, Barron M. F.	Hammond	Lake	Pemberton, Jack J.	Evansville	Vanderburgh
Palmer, Charman F.	Indianapolis	Marion	Penn, Robert A.	East Gary	Lake
Palmer, Harley P.	Indianapolis	Marion	Pennington, W. E. (S)	Indianapolis	Marion
Palmer, Robert M.	Indianapolis	Marion	Pentecost, Paul S.	Richmond	Wayne-Union
Palmer, Robert W.	Indianapolis	Marion	Perkins, Powell L.	Kokomo	Howard
Panares, Solomon V.	Hammond	Lake	Perlov, Sylvan H.	Indianapolis	Marion
Pancost, Vernon K.	Elkhart	Elkhart	Permer, Erwin	Indianapolis	Marion
Pandolfo, Harry	Indianapolis	Marion	Perrin, Kermit F.	Fort Wayne	Allen
Panos, Constantine O.	Bluffton	Wells	Perry, Frederic G.	Fort Wayne	Allen
Pappas, Eddie T.	Gary	Lake	Person, Theodore C.	Veedersburg	Fountain-Warren
Paris, Durward W.	Kokomo	Howard	Peters, Elmer E.	Brookville	Fayette-Franklin
Paris, John M.	New Albany	Floyd	Peterson, Deward D.	Indianapolis	Marion
Park, Byron J.	Richmond	Wayne-Union	Peterson, Joel A.	Lafayette	Tippecanoe
			Peterson, Roland L.	Plymouth	Marshall
			Petitjean, Harold G.	Haubstadt	Gibson
			Petranoff, Theodore V. (S)	Indianapolis	Marion
			Petrass, Andrew	South Bend	St. Joseph

Name	City	County
Petrich, Peter R.	Attica	Fountain-Warren
Petry, T. Neal	Delphi	Carroll
Pettijohn, Fred L. (S)	Indianapolis	Marion
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, Dudley A.	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Pfuetze, Max	Logansport	Cass
Phares, Robert W.	Kokomo	Howard
Phelps, Stephen R.	South Bend	St. Joseph
Phelps, William J.	Fort Wayne	Allen
Philbert, Richard N.	Daly City, Calif.	Allen
Philbrook, Seth S.	La Porte	La Porte
Phillips, David L.	Indianapolis	Marion
Phillips, John H.	Michigan City	La Porte
Phipps, Elwood B.	Logansport	Cass
Phipps, Leland K.	Union City	Randolph
Pickett, Merle E.	Fort Wayne	Allen
Pickett, Robert D.	Indianapolis	Marion
Pierce, Emmett, Jr.	Indianapolis	Marion
Pierce, Frederick H.	Anderson	Madison
Pierce, Gene S.	New Albany	Floyd
Pierson, Pearl H.	Silver Lake	Kosciusko
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pietz, David G.	Bluffton	Wells
Pike, Warren H.	Hobart	Lake
Pilcher, Jack E.	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	La Porte
Pilot, Jean	Hammond	Lake
Pippenger, Wayne G.	Muncie	Delaware-Blackford
Pirkle, Hubert B.	Rockville	Parke-Vermillion
Pizzo, Anthony	Bloomington	Owen-Monroe
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	La Porte
Plasterer, Edward D.	Richmond	Wayne-Union
Ploetner, Edward J.	Jasper	Dubois
Ploughe, Ralph R.	Elwood	Madison
Polhemus, Warren C.	Anderson	Madison
Polite, Nicholas L.	Whiting	Lake
Pollard, Walter S. (S)	Evansville	Vanderburgh
Ponczek, Edward J.	Fort Wayne	Allen
Poolitsan, George C.	Bloomington	Owen-Monroe
Popp, Milton F.	Fort Wayne	Allen
Popplewell, Arvine G.	Indianapolis	Marion
Porack, Bernard F.	Gary	Lake
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, Edward A.	Westport	Decatur
Porter, George S.	Richmond	Wayne-Union
Porter, Jack	Lebanon	Boone
Porter, Robert A.	Westport	Decatur
Portney, Fred R.	Hammond	Lake
Portteus, Walter L.	Franklin	Johnson
Poston, Clement L.	Laurel	Fayette-Franklin
Potter, Richard M.	Ridgeville	Randolph
Powell, J. Paxton	Marion	Grant
Powell, M. Jack	Fort Wayne	Allen
Powell, Richard C.	Denver, Colo.	Marion
Prather, Philip E.	Kokomo	Howard
Pratt, Ralph M., Jr.	Madison	Jefferson-Switzerland
Predd, Adolph C.	La Porte	La Porte
Premuda, Franklin F.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson-Switzerland
Prentiss, Nelson H.	Oteen, N. C.	Allen

Name	City	County
Present, Julian	Evansville	Vanderburgh
Pribble, Robert H.	Indianapolis	Marion
Price, Ambrose M.	Marion	Grant
Price, Douglas W.	Nappanee	Elkhart
Price, Francis W.	Indianapolis	Marion
Price, James O.	Indianapolis	Marion
Price, Shirley G.	Evansville	Vanderburgh
Priddy, Marvin E.	Fort Wayne	Allen
Priebe, Fred H.	Indianapolis	Marion
Proudfit, Charles H.	South Bend	St. Joseph
Province, Oran A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, J. Edward	Gary	Lake
Pryor, Richard C.	Indianapolis	Marion
Pu, Pin H.	Terre Haute	Vigo
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, Bertrand H.	Wolcottville	Noble
Purcell, Richard J.	Griffith	Lake
Puterbaugh, Karl E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph

Q

Quarles, E. Bryan	Bloomington	Owen-Monroe
Quick, William J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (S)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
Quilty, Thomas J.	Goshen	Elkhart

R

Rabb, Aaron	Indianapolis	Marion
Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry S.	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Gary	Lake
Rafalski, Thomas A.	Indianapolis	Marion
Ragan, William D.	Indianapolis	Marion
Rainey, Everett A. (S)	Lebanon	Boone
Ralston, John D.	Indianapolis	Marion
Ramage, Walter F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	Hammond	Lake
Ramos, Alfonso	Gary	Lake
Ramos, John	East Chicago	Lake
Ramsdell, Glen A.	Richmond	Wayne-Union
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, Hugh S.	Bloomington	Owen-Monroe
Ranck, Benjamin	Columbus	Bartholomew-Brown
Raney, Ben B.	Linton	Greene
Rang, A. A. (S)	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Rapp, George F.	Indianapolis	Marion
Rasch, George C., Jr.	Hammond	Lake
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratcliffe, Albert W.	Evansville	Vanderburgh
Rau, Charles A.	Columbus	Bartholomew-Brown
Rauh, Robert A.	Wabash	Wabash
Rausch, Norman W.	Angola	Steuben
Rawlins, Carolyn M.	Hammond	Lake
Rawls, George H.	Indianapolis	Marion
Ray, Carl S.	Warren	Huntington
Ray, Herbert A. (S)	Fort Wayne	Allen
Raymundo, Vivencio F.	Attica	Fountain-Warren
Read, John E.	Chesterton	Porter
Reck, John L. (S)	Sheridan	Hamilton
Records, Arthur W.	Franklin	Johnson

Name	City	County	Name	City	County
Reed, Donald	Culver	Marshall	Rieger, I. Taylor	Bloomington	Owen-Monroe
Reed, Edsel S.	Jeffersonville	Clark	Rietman, H. Jerome	Evansville	Vanderburgh
Reed, John	Hobart	Lake	Rifner, Eugene S.	Van Buren	Grant
Reed, John D.	Detroit, Mich.	Clinton	Rigg, John F.	Miami Shores, Fla.	Marion
Reed, Nelle C. (S)	Michigan City	La Porte	Riggs, Floyd C.	Terre Haute	Vigo
Reed, Philip B.	Indianapolis	Marion	Rigley, Edward L.	South Bend	St. Joseph
Reed, Robert C.	Terre Haute	Vigo	Rimel, James F.	Plymouth	Marshall
Reed, Robert F.	Mishawaka	St. Joseph	Riner, Jack K.	Indianapolis	Marion
Reed, Roger R.	Andersen	Madison	Rinne, John I. (S)	Lapel	Madison
Reed, William C.	Bloomington	Owen-Monroe	Riordan, John F.	Gary	Lake
Reeder, Henry H.	Jeffersonville	Clark	Ripley, John W.	Seymour	Jackson
Rees, Russel C.	Indianapolis	Marion	Rissing, Walter J.	Fort Wayne	Allen
Regan, George L.	Sellersburg	Clark	Ritchey, James O.	Indianapolis	Marion
Reibel, Donald B.	New York, N. Y.	Marion	Ritchie, William D.	Evansville	Vanderburgh
Reich, Clarence E.	Evansville	Vanderburgh	Rittelmeyer, Louis F., Jr.	Evansville	Vanderburgh
Reid, Charles A.	Indianapolis	Marion	Ritterman, George W.	Franklin	Johnson
Reid, Donald B.	Columbia City	Whitley	Ritter, Wayne L.	Indianapolis	Marion
Reid, James D.	Marion	Grant	Ritz, Albert S.	Evansville	Vanderburgh
Reid, Robert M.	Columbus	Bartholomew-Brown	Rivers, Glynn A.	Muncie	Delaware-Blackford
Reid, Robert W. (S)	Union City	Randolph	Robb, John A.	Indianapolis	Marion
Reilly, Eva Ferro	Beech Grove	Marion	Roberts, Billy J.	South Bend	St. Joseph
Reilly, James F.	Vincennes	Knox	Robertson, Addis N.	New Albany	Floyd
Reilly, Richard W.	Crete, Ill.	Lake	Robertson, David W. (S)	Deputy	Jefferson-Switzerland
Reisler, Simon (S)	Indianapolis	Marion	Robertson, James S.	Plymouth	Marshall
Reitman, Paul H.	East Chicago	Lake	Robertson, Ray B.	Indianapolis	Marion
Remich, Antone C.	Hammond	Lake	Robertson, William C.	Chesterton	Porter
Renbarger, Lester L.	Marion	Grant	Robertson, William S.	Spiceland	Henry
Rendel, Donald T.	Hammond	Lake	Robinson, Earle U.	Evansville	Vanderburgh
Rendel, Harold E.	Mexico	Miami	Robinson, Frank C. (S)	Newport Beach, Calif.	Marion
Rentschler, Lewis C. (S)	Clay City	Clay	Robinson, Nan	New Albany	Floyd
Repay, Walter A.	Hammond	Lake	Robinson, Walter K.	Gary	Lake
Reppert, Roland L.	Decatur	Adams	Robinson, William H.	Bedford	Lawrence
Rettig, Arthur C.	Muncie	Delaware-Blackford	Roby, Alma L.	Jeffersonville	Clark
Reuter, John W.	Indianapolis	Marion	Rochlin, Isidore	Indianapolis	Marion
Reynolds, James S.	Gary	Lake	Rockey, Noah A.	Fort Wayne	Allen
Reynolds, Ralph E.	Middletown	Henry	Rodin, Herman H.	South Bend	St. Joseph
Reynolds, R. Perry	Garrett	De Kalb	Rodriguez, Cecilio	East Chicago	Lake
Reynolds, Richard J.	Terre Haute	Vigo	Rodriguez, Juan	Fort Wayne	Allen
Rhamy, Arthur P.	Marion	Grant	Roesch, Ryland	Indianapolis	Marion
Rhamy, Donald E.	Marion	Grant	Roeske, Nancy A.	Indianapolis	Marion
Rhamy, Robert K.	Indianapolis	Marion	Rogers, Arthur R.	Newburgh	Warrick
Rhea, James C.	Beech Grove	Marion	Rogers, Donald L.	Indianapolis	Marion
Rheinheimer, Floyd L.	Milford	Kosciusko	Rogers, Evered E.	Auburn	De Kalb
Rhind, Alexander W.	Hammond	Lake	Rogers, Otto F.	Bloomington	Owen-Monroe
Rhodes, Theodore D.	Nokomis, Fla.	Marion	Rogers, R. Shirrell	West Terre Haute	Vigo
Rhorer, Herbert M.	Kokomo	Howard	Rogers, Thomas P.	Indianapolis	Marion
Rhorer, John G.	Marion	Grant	Rohn, Robert J.	Indianapolis	Marion
Rhynearson, Hal R.	Fortville	Hancock	Rohrbacker, Donald M.	Portland, Ore.	Marion
Rice, Frederic A.	Indianapolis	Marion	Rohrer, Bryce B.	Walkerton	St. Joseph
Rice, Raymond M.	Indianapolis	Marion	Rohrer, James R.	Elnora	Daviess-Martin
Rice, Reed P.	Rochester, Minn.	Marion	Roll, John W.	Indianapolis	Marion
Rice, Wilkie B. (S)	Fort Wayne	Allen	Roll, William A.	Marion	Grant
Rich, Norval	Decatur	Adams	Roller, Charles W. (S)	Indianapolis	Marion
Richard, Norman F.	Shelbyville	Shelby	Rollins, Thomas K.	Bloomington	Owen-Monroe
Richards, David H. (S)	Vincennes	Knox	Romberger, Floyd T., Jr.	Indianapolis	Marion
Richards, Edgar E.	Russellville	Putnam	Romero, Plinio	Gary	Lake
Richardson, Charles L.	Rochester	Fulton	Rommel, Clarence H.	W. Lafayette	Tippecanoe
Richardson, Joseph H.	Marion	Grant	Roose, Lisle W.	Nappanee	Elkhart
Richardson, Thad T.	Indianapolis	Marion	Ropp, Eldon R.	Oakland City	Gibson
Richard, James V.	Terre Haute	Vigo	Ropp, Harold E.	New Harmony	Posey
Richer, Orville H.	Warsaw	Kosciusko	Rosenak, Bernard D.	Indianapolis	Marion
Richmond, Harold W.	Columbus	Bartholomew-Brown	Rosenbaum, Irving, Jr.	Indianapolis	Marion
Richter, Arthur B.	Indianapolis	Marion	Rosenbaum, Lloyd E.	Anderson	Madison
Richter, John C.	La Porte	La Porte	Rosenblatt, Bernard B.	Evansville	Vanderburgh
Richter, Samuel	Gary	Lake	Rosenbloom, Philip J.	Gary	Lake
Ricketts, Joseph W. (S)	Orman Beach, Fla.	Marion	Rosenheimer, George M.	South Bend	St. Joseph
Ridgeway, Ora W. (S)	Indianapolis	Marion	Rosenthal, Carl	Hammond	Lake
Ridgway, Alton H.	Lapel	Madison	Rosenwasser, Jacob	Mishawaka	St. Joseph
Ridolfo, Anthony S.	Indianapolis	Marion	Roser, Arthur J.	Fort Wayne	Allen
			Rosevear, Henry J.	Hammond	Lake

Name	City	County	Name	City	County
Ross, Alexander T.	Indianapolis	Marion	Sahlman, Hans	Fort Wayne	Allen
Ross, Ben R.	Bloomington	Owen-Monroe	Saint, William K.	New Castle	Henry
Ross, David E., Jr.	Gary	Lake	Sala, Joseph J.	Gary	Lake
Ross, Glenn E.	Washington	Daviess-Martin	Sala, Walter R.	Gary	Lake
Ross, Guy E.	Anderson	Madison	Salb, John P.	Jasper	Dubois
Ross, Harry P.	Richmond	Wayne-Union	Salb, Leo A. (S)	Jasper	Dubois
Ross, James B.	Bloomington	Owen-Monroe	Salb, Max C.	Indianapolis	Marion
Ross, James S.	Richmond	Wayne-Union	Salon, Harry W.	Fort Wayne	Allen
Rossiter, Dudley L.	Fort Wayne	Allen	Salon, Joel W.	Fort Wayne	Allen
Roth, Bertram S.	Indianapolis	Marion	Salon, Nathan L.	Fort Wayne	Allen
Roth, James R.	Wolf Lake	Noble	Salzburg, Herbert E.	Westville	La Porte
Roth, Leo	Gary	Lake	Samter, Thomas G.	Indianapolis	Marion
Roth, Melvin I.	Gary	Lake	Sanders, Bertram W.	Connersville	Fayette-Franklin
Rothberg, Maurice	Fort Wayne	Allen	Sanders, Harry M.	Indianapolis	Marion
Rothrock, Philip W.	Lafayette	Tippecanoe	Sanders, Jesse A. (S)	Auburn	De Kalb
Rotman, Harry G.	Jasonville	Greene	Sanderson, Robert B.	South Bend	St. Joseph
Rotman, Sam I.	Jasonville	Greene	Sandock, Isadore	South Bend	St. Joseph
Rouen, Robert	Elkhart	Elkhart	Sandock, Louis F.	South Bend	St. Joseph
Rousseau, John W.	Fort Wayne	Allen	Sandoz, Harry H.	South Bend	St. Joseph
Row, D. Hamilton	Indianapolis	Marion	Santare, Vincent J.	Munster	Lake
Row, George S.	Osgood	Ripley	Santiago, Iuminada	Hammond	Lake
Row, Perrie Q.	Hammond	Lake	Sargent, Wallace B.	Hammond	Lake
Rowe, Howard H.	Rochester	Fulton	Sarver, Francis E.	Fort Wayne	Allen
Royster, George M. (S)	Evansville	Vanderburgh	Savage, Arthur R.	Fort Wayne	Allen
Royster, Robert A.	Evansville	Vanderburgh	Sayers, Frank E. (S)	Terre Haute	Vigo
Rozelle, Clarence V.	Anderson	Madison	Saylors, Rodger D.	Fort Wayne	Allen
Rubens, Eli	South Bend	St. Joseph	Sazama, Francis J.	East Chicago	Lake
Rubin, Milton M.	Terre Haute	Vigo	Scales, Alfred B.	Huntingburg	Dubois
Rubin, Simon S.	Gary	Lake	Scales, Allen D.	Huntingburg	Dubois
Rubright, Robert L.	Hammond	Lake	Scamahorn, Malcolm O.	Pittsboro	Hendricks
Ruby, Fred McK. (S)	Wauwatosa, Wis.	Randolph	Scamahorn, Oscar T. (S)	Pittsboro	Hendricks
Rucker, Warren R.	Madison	Jefferson-Switzerland	Scea, Wallace A.	Elwood	Madison
Ruddell, Karl R. (S)	Indianapolis	Marion	Schaaf, Alvin D.	Jamestown	Boone
Ruddell, Keith R.	Indianapolis	Marion	Schafer, William C.	Washington	Daviess-Martin
Rudesill, Cecil L. (S)	Indianapolis	Marion	Schaffer, Edward V.	Indianapolis	Marion
Rudesill, Robert I.	Indianapolis	Marion	Schantz, Richard	Remington	Jasper-Newton
Rudicel, Max	Kokomo	Howard	Schaphorst, Richard A.	South Bend	St. Joseph
Rudolph, Carl J.	South Bend	St. Joseph	Scharbrough, William	Ewing	Jackson
Rudolph, Franklin G.	Munster	Lake	Schauwecker, Cleon M.	Greencastle	Putnam
Rudolph, Kenneth J.	Indianapolis	Marion	Schechter, John S.	Indianapolis	Marion
Rudolph, Stephen J., Jr.	Cannon AFB, New Mexico	Marion	Scheeringa, Ronald H.	Indianapolis	Marion
Rudser, Donald H.	Whiting	Lake	Scheetz, Marion R.	Lewisville	Henry
Rudy, Donald B.	Nashville, Tenn.	Wells	Scheier, Emil W.	Indianapolis	Marion
Runge, Paul W.	Richmond	Wayne-Union	Scheimann, Lois	Valparaiso	Porter
Rupe, Lloyd O.	Elkhart	Elkhart	Schellhouse, Earl M.	St. Louis, Mo.	Allen
Rupel, Ernest	Clearwater, Fla.	Marion	Schenck, Foss (S)	Logansport	Cass
Rupper, Warren R.	Evansville	Vanderburgh	Schenck, Ralph E.	Portland	Jay
Rusche, Henry J.	Evansville	Vanderburgh	Scherb, Burton E.	Terre Haute	Vigo
Ruschli, Edward B. (S)	Lafayette	Tippecanoe	Scherschel, John P.	Bedford	Lawrence
Rusk, Hubert M.	Wallace	Fountain-Warren	Schetgen, Joseph V.	Geneva	Adams
Russell, John R.	Indianapolis	Marion	Scheurich, Virgil	Oxford	Benton
Russell, Richard H.	Evansville	Vanderburgh	Schiller, Herbert A.	South Bend	St. Joseph
Russo, Andrew E.	Crown Point	Lake	Schimmelpfennig, Robert W.	Evansville	Vanderburgh
Rust, Byron K.	Indianapolis	Marion	Schirmer, Robert H.	Evansville	Vanderburgh
Rust, Roland B.	Indianapolis	Marion	Schlademan, Karl R.	Fort Wayne	Allen
Ruth, Martin L.	Indianapolis	Marion	Schlaegel, Theo. F., Jr.	Indianapolis	Marion
Rutherford, Cyrus W. (S)	Indianapolis	Marion	Schlegel, Donald M.	Indianapolis	Marion
Rutherford, Charles E.	Otterbein	Benton	Schlemmer, George H.	Warsaw	Kosciusko
Ryan, Glen V.	Indianapolis	Marion	Schlesinger, Daniel J.	Hammond	Lake
Ryan, Hubert J.	Gary	Lake	Schloss, Robert P.	Fort Wayne	Allen
Ryan, William J.	Columbus	Bartholomew-Brown	Schlosser, Herbert C.	Elkhart	Elkhart
Sabens, James A.	Scottsburg	Scott	Schmalhausen, Ansel W.	Indianapolis	Marion
Sacks, Leonard Z.	Valparaiso	Porter	Schmidt, Eugene E.	Fort Wayne	Allen
Sage, Charles V.	Richmond	Wayne-Union	Schmidt, Loren F.	Indianapolis	Marion
Sage, Russell A.	Indianapolis	Marion	Schmidt, Richard H.	Valparaiso	Porter
			Schmiedicke, Paul H.	Lafayette	Tippecanoe
			Schmitt, Richard K.	Columbus	Bartholomew-Brown
			Schmitt, Robert J.	Gary	Lake

Name	City	County	Name	City	County
Schmoll, Robert J.	Fort Wayne	Allen	Seyler, Anna G.	La Verne, Calif.	Lake
Schmoyer, Maurice R.	Indianapolis	Marion	Shafer, Marion R.	Indianapolis	Marion
Schneider, Carl J.	Indianapolis	Marion	Shafer, Richard H.	Alexandria	Madison
Schneider, Charles P.	Evansville	Vanderburgh	Shaffer, Kenneth L.	Vincennes	Knox
Schneider, Kenneth D.	Nashville	Bartholomew-Brown	Shaffer, William R.	Greensburg	Decatur
Schneider, Louis A.	Fort Wayne	Allen	Shallenberger, Henry R.	Modoc	Randolph
Schnute, Richard B.	Indianapolis	Marion	Shanafelt, Donald K.	Indianapolis	Marion
Schoen, Frederic L.	Fort Wayne	Allen	Shanklin, Jack L.	Bicknell	Knox
Schoolfield, William E.	Orleans	Orange	Shanklin, Vernon A. (S)	Terre Haute	Vigo
Schoonveld, Arthur	Brook	Jasper-Newton	Shanks, Ray W.	Noblesville	Hamilton
Schott, Edward J. (S)	Terre Haute	Vigo	Shannon, Wesley E.	Crawfordsville	Montgomery
Schreiner, John E.	Bremen	Marshall	Shapiro, Burton J.	Indianapolis	Marion
Schrepferman, Wayne	Hamilton	Steuben	Shapiro, Joseph	East Chicago	Lake
Schriefer, Victor V.	Evansville	Vanderburgh	Shapiro, Seymour W.	East Chicago	Lake
Schroeder, Henry R.	Washington	Daviess-Martin	Sharp, Merle C.	South Bend	St. Joseph
Schroeder, Robert W.	Marion	Grant	Sharp, William L.	Anderson	Madison
Schubert, Jerome C.	Fort Wayne	Allen	Shattuck, John C.	Brazil	Clay
Schuchman, Abe	Indianapolis	Marion	Shaw, Houston W.	Jeffersonville	Clark
Schuchman, Gabriel	Indianapolis	Marion	Shaw, James E.	Fort Wayne	Allen
Schulfer, Richard J.	Hammond	Lake	Shecter, Harry	Hammond	Lake
Schulhof, Maurice G.	Muncie	Delaware-Blackford	Sheehan, Francis G.	Indianapolis	Marion
Schulz, Kurt J.	Gary	Lake	Sheek, Kenneth I.	Greenwood	Johnson
Schulze, William	Vincennes	Knox	Sheets, Charles E.	Manilla	Rush
Schumaker, Robert A.	Terre Haute	Vigo	Sheldon, Suel A.	Anderson	Madison
Schuman, Edith B.	Bloomington	Owen-Monroe	Shelley, Edward S.	South Bend	St. Joseph
Schuster, Dwight W.	Indianapolis	Marion	Shelley, Richard J.	Indianapolis	Marion
Schwartz, Frederick C.	Kokomo	Howard	Shellhouse, Michael	Gary	Lake
Schwartz, Jack	Hammond	Lake	Shelton, Clyde F.	New Albany	Floyd
Schwartz, Mary M.	Hammond	Lake	Shenk, Earl M. (S)	Kokomo	Howard
Schwarz, Anton	Indianapolis	Marion	Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Scotfield, John B.	Indianapolis	Marion	Sherer, Kenneth E.	Richmond	Wayne-Union
Scotts, William H.	Fort Wayne	Allen	Sherster, Harry	Indianapolis	Marion
Scott, Frank M.	South Bend	St. Joseph	Sherwood, Clarence E.	Fort Wayne	Allen
Scott, George E.	Indianapolis	Marion	Sherwood, J. Vincent	Fort Wayne	Allen
Scott, H. Vaughn	Fort Wayne	Allen	Shevick, Alexander	Gary	Lake
Scott, Irvin H.	Sullivan	Sullivan	Shields, Jack E.	Brownstown	Jackson
Scott, I. Winfield	Indianapolis	Marion	Shields, Tom S.	Richmond	Wayne-Union
Scott, John S.	La Porte	La Porte	Shina, Heskell S.	Charlestown	Clark
Scott, John R.	Indianapolis	Marion	Shinabery, Lawrence	Fort Wayne	Allen
Scott, Robert P.	Indianapolis	Marion	Shiple, Edward	Indianapolis	Marion
Scott, Robert S.	Charlottesville	Hancock	Shively, John L.	Lafayette	Tippecanoe
Scott, Samuel L.	Indianapolis	Marion	Shoemaker, Richard L.	Gas City	Grant
Scott, V. Brown	Shelbyville	Shelby	Sholtz, William M.	Lafayette	Tippecanoe
Scudder, Arthur N.	Brownsburg	Hendricks	Shoptaugh, A. Glenn, Jr.	Wichita Falls, Texas	Marion
Scully, John T.	Gary	Lake	Short, John T. (S)	Fort Wayne	Allen
Seal, Perry F.	Brookville	Fayette-Franklin	Shoup, Homer B.	Greentown	Howard
Seaman, Charles F.	Indianapolis	Marion	Showalter, John P.	Waterloo	De Kalb
Sears, Don	Odon	Daviess-Martin	Showalter, John R.	Terre Haute	Vigo
Sears, M. Maywood (S)	Elkhart	Elkhart	Shrader, Carl E.	Warsaw	Kosciusko
Seat, Marshall H.	Washington	Daviess-Martin	Shriner, Richard L.	South Bend	St. Joseph
Sedam, Herbert L.	Indianapolis	Marion	Shroyer, Herbert	Dunkirk	Jay
Seese, Robert M.	Delphi	Carroll	Shuck, William A.	Madison	Jefferson-Switzerland
Segar, Louis H. (S)	Indianapolis	Marion	Shullenberger, Wendell A.	Indianapolis	Marion
Segar, William E.	Indianapolis	Marion	Shulruff, Harry I.	East Chicago	Lake
Seibel, Robert M.	Nashville	Bartholomew-Brown	Shumacker, Harris B., Jr.	Indianapolis	Marion
Seipel, Stanley	Lanesville	Harrison-Crawford	Sibbitt, Joseph W.	Bloomington	Owen-Monroe
Selby, Keith E.	South Bend	St. Joseph	Sicks, Okla W.	Indianapolis	Marion
Sellers, Francis M.	South Bend	St. Joseph	Sidebottom, Earl W.	Indianapolis	Marion
Sellmer, George W.	Indianapolis	Marion	Sidell, James P.	New Haven	Allen
Senese, Thomas J.	Gary	Lake	Siderys, Harry	Indianapolis	Marion
Sennett, Cecil M. (S)	Westville	La Porte	Siebe, Jack C.	Indianapolis	Marion
Sennett, William K.	Macy	Miami	Siebenmorgen, Louis (S)	Terre Haute	Vigo
Senseny, Eugene F.	Fort Wayne	Allen	Siebenmorgen, Paul	Terre Haute	Vigo
Sensenich, Roscoe L. (H)	South Bend	St. Joseph	Siekierski, Joseph M.	Griffith	Lake
Serna, Jesus A.	East Chicago	Lake	Siersdorfer, Theodore N. (S)	Indianapolis	Marion
Seward, George W.	North Manchester	Wabash	Sigmond, Harvey W.	Indianapolis	Marion
Sexson, Hiram T.	Indianapolis	Marion	Sigmund, William B.	Columbus	Bartholomew-Brown

Name	City	County	Name	City	County
Silbert, David B.	Shelbyville	Shelby	Smitley, Roger P.	Hammond	Lake
Silver, Richard A.	Indianapolis	Marion	Smoot, Emory B.	Washington	Daviess-Martin
Silverman, Norman M.	Terre Haute	Vigo	Smoot, Samuel A. (S)	Terre Haute	Vigo
Silvian, Harry A.	Whiting	Lake	Snapp, Richard A.	Columbus	Bartholomew-Brown
Simmons, Frederick H.	Marion	Grant	Sneary, Kenneth D.	Avilla	Noble
Simmons, James E.	Indianapolis	Marion	Sneary, Max E.	Avilla	Noble
Simmons, Lloyd H.	Goshen	Elkhart	Snider, Byron	Indianapolis	Marion
Simms, J. Leon	Indianapolis	Marion	Snively, William D., Jr.	Evansville	Vanderburgh
Simpson, Robert L.	Bluffton	Wells	Snodgrass, Robert E.	Greenwood	Johnson
Simpson, William D.	Indianapolis	Marion	Snowwhite, Arthur B.	Marion	Grant
Sims, J. Lawrence	Indianapolis	Marion	Snyder, Earl R. (S)	Troy	Perry
Singer, Elmer C. (S)	Fort Wayne	Allen	Snyder, Jerome A.	Hammond	Lake
Singer, Paul J.	Jasper	Dubois	Snyder, Morris C.	Richmond	Wayne-Union
Sinn, Charles M.	Evansville	Vanderburgh	Snyder, Parker M.	Peru	Miami
Sirlin, Edward M.	Mishawaka	St. Joseph	Snyderman, Sanford C.	Fort Wayne	Allen
Sisk, Phillip B.	Indianapolis	Marion	Sobol, Z. W.	Elkhart	Elkhart
Sisson, Norvel D.	South Bend	St. Joseph	Sokol, Allen B.	Whiting	Lake
Skeen, Earl D. (S)	Walkerton	St. Joseph	Solis, Roger V.	Hammond	Lake
Skillern, Penn G. (S)	South Bend	St. Joseph	Solomon, Reuben A.	Indianapolis	Marion
Skillern, Scott D.	South Bend	St. Joseph	Somers, Gerald H.	Fort Wayne	Allen
Skomp, Claud E.	Marion	Grant	Sommers, Stephen D.	Dayton, Ohio	Marion
Slabaugh, Jancy S. (S)	Nappanee	Elkhart	Sonne, Irvin S., Jr.	New Albany	Floyd
Slama, George F.	Gary	Lake	Soper, Hunter A.	Indianapolis	Marion
Slama, John T.	Gary	Lake	Sorenson, Raymond	Kokomo	Howard
Slaughter, Howard C.	Evansville	Vanderburgh	Souder, Bonnell M.	Auburn	De Kalb
Slaughter, John C.	Evansville	Vanderburgh	Souter, Martha C.	Indianapolis	Marion
Slaughter, Owen L.	Evansville	Vanderburgh	Southard, Carl B.	Noblesville	Hamilton
Slichenmyer, Jack E.	Chicopee Falls, Mass.	Marion	Southard, James E.	Danville	Hendricks
Slick, Crystal R.	Winchester	Randolph	Southworth, John W.	Indianapolis	Marion
Sloan, Herbert P.	New Albany	Floyd	Sovine, Joe W.	Indianapolis	Marion
Sloan, W. Keith	Madison	Jefferson-Switzerland	Spahr, Donald E.	Portland	Jay
Slominski, Harry H. (S)	South Bend	St. Joseph	Spahr, John F., Jr.	Indianapolis	Marion
Slough, O. Thomas	Kendallville	Noble	Spalding, Joseph J.	Indianapolis	Marion
Sluss, David H.	Indianapolis	Marion	Spalding, Wendell L.	Mishawaka	St. Joseph
Sluss, John W. (S)	Indianapolis	Marion	Spangler, Jesse S.	Kokomo	Howard
Smith, A. Wilson	Greencastle	Putnam	Sparks, Alan L.	Indianapolis	Marion
Smith, Barton T.	Marion	Grant	Sparks, Paul W.	Winchester	Randolph
Smith, Byron J.	Kingman	Fountain-Warren	Spears, John K.	Paoli	Orange
Smith, Charles F.	Noblesville	Hamilton	Spears, John M.	Indianapolis	Marion
Smith, David L.	Indianapolis	Marion	Speas, Robert C.	Terre Haute	Vigo
Smith, Edward B.	Indianapolis	Marion	Speck, Carlson R.	Muncie	Delaware-Blackford
Smith, E. Rogers	Indianapolis	Marion	Speckman, Glenn H.	Indianapolis	Marion
Smith, Francis C.	Indianapolis	Marion	Spellman, Frank W.	Gary	Lake
Smith, Fred, Jr.	Tell City	Perry	Spencer, Beaufort A.	Bloomington	Owen-Monroe
Smith, Frederick R.	Spencer	Owen-Monroe	Spencer, Frederic	Vincennes	Knox
Smith, Gloster J.	Kokomo	Howard	Spencer, C. Herbert	Fort Wayne	Allen
Smith, Herbert N.	Brookville	Fayette-Franklin	Spenner, Raymond W.	South Bend	St. Joseph
Smith, Herschel S.	Bloomington	Owen-Monroe	Spindler, Robert D.	Shelbyville	Shelby
Smith, James S.	Muncie	Delaware-Blackford	Spivack, Mary	Gary	Lake
Smith, Jerald E.	Hammond	Lake	Spivey, Russell J.	Indianapolis	Marion
Smith, John H.	Greenfield	Hancock	Spolyar, Louis W.	Indianapolis	Marion
Smith, John R.	Richmond	Wayne-Union	Sponder, Joseph (S)	Gary	Lake
Smith, Lee Jr.	Castaner, Puerto Rico	St. Joseph	Spray, Page E.	Elkhart	Elkhart
Smith, Lloyd H.	North Manchester	Wabash	Sprecher, Herman C.	Evansville	Vanderburgh
Smith, Lowell C.	Lafayette	Tippecanoe	Sprenger, Thomas R.	Tampa, Fla.	Marion
Smith, Mark E.	New Castle	Henry	Springstun, George H.	Oaktown	Knox
Smith, Philip L.	Fort Wayne	Allen	Springstun, Walter R.	Evansville	Vanderburgh
Smith, Ralph O.	Vincennes	Knox	Sputh, Carl B., Jr.	Indianapolis	Marion
Smith, Richard B.	Fort Wayne	Allen	Sroka, Alexander G.	Hammond	Lake
Smith, Robert D.	Lowell	Lake	Sroka, Stanley J.	Highland	Lake
Smith, Rodney D. (S)	Bloomington	Owen-Monroe	Stach, Thomas W.	Indianapolis	Marion
Smith, R. Lee	Osgood	Ripley	Stadler, Harold E.	Indianapolis	Marion
Smith, Roger C.	Fort Wayne	Allen	Staff, Robert A.	Terre Haute	Vigo
Smith, Roy Lee	Indianapolis	Marion	Stafford, William C.	Plainfield	Hendricks
Smith, Roy M.	Evansville	Vanderburgh	Stahl, Edward T.	Lafayette	Tippecanoe
Smith, S. Joseph	Vincennes	Knox	Stallings, Hugh A.	Evansville	Vanderburgh
Smith, Stephen D.	Knightstown	Henry	Stallman, Carl F.	Kendallville	Noble
Smith, Theodore J.	Whiting	Lake	Stalter, Gaylord W.	North Webster	Kosciusko
Smith, William B.	Indianapolis	Marion	Stamper, Joseph H.	Anderson	Madison
Smith, William M.	Westville	La Porte	Stamper, Lucian A.	Richmond	Wayne-Union
			Stamper, Robert J.	Anderson	Madison
			Stander, Richard W.	Indianapolis	Marion
			Stangle, William J.	Bloomington	Owen-Monroe
			Stanley, John S.	Miami, Fla.	Marion

Name	City	County	Name	City	County
Stanley, Robert G.	Fort Wayne	Allen	Stover, Wendell C.	Boonville	Warrick
Stansbury, William E.	Indianapolis	Marion	Stoycoff, Christ M. (S)	Gary	Lake
Stansell, Gilbert B.	Lafayette	Tippecanoe	Strang, William C.	Indianapolis	Marion
Starks, William O.	Anderson	Madison	Stratigos, Joseph S.	Evanston, Ill.	St. Joseph
Starr, Albert M.	Erie, Pa.	Allen	Strayer, Joseph W.	Lafayette	Tippecanoe
Stasick, Murray	Hammond	Lake	Streck, Francis A.	Lawrenceburg	Dearborn-Ohio
Staten, Jesse C.	Indianapolis	Marion	Strecker, William L.	Terre Haute	Vigo
Stauffer, George E.	Mooreland	Henry	Streepey, Jefferson I.	New Albany	Floyd
Stauffer, Richard C.	Fort Wayne	Allen	Streeter, Ralph T.	Indianapolis	Marion
Stauffer, Walter A. (S)	Elkhart	Elkhart	Stricker, Paul J.	New Castle	Henry
Staunton, Henry A.	South Bend	St. Joseph	Strickland, Karl S. (S)	Princeton	Gibson
Stayton, Chester A., Jr.	Indianapolis	Marion	Strickland, Neil R.	Indianapolis	Marion
Steckler, Robert J.	Garden Grove, Calif.	Vanderburgh	Strong, Daniel S. (S)	Terre Haute	Vigo
Stecy, Peter	Whiting	Lake	Stroup, Tyler J.	Indianapolis	Marion
Steele, Dick J.	Greencastle	Putnam	Strueh, Paul E.	Evansville	Vanderburgh
Steele, Everett B.	Crown Point	Lake	Stubbins, William M.	Elkhart	Elkhart
Steele, Frank M.	Muncie	Delaware-Blackford	Stucky, Elsworth K.	Indianapolis	Marion
Steele, Hugh H.	Lafayette	Tippecanoe	Stucky, Jerry L.	Fort Wayne	Allen
Steele, Paul W.	Evansville	Vanderburgh	Studebaker, Lloyd R.	LaGrange	LaGrange
Steen, Lowell H.	Whiting	Lake	Stultz, Quentin F.	Ligonier	Noble
Steffen, Arthur J.	Wabash	Wabash	Stumer, Myer	Michigan City	La Porte
Steffen, Julian T.	Wabash	Wabash	Stump, Loyd K.	Indianapolis	Marion
Steffy, Ralph M.	Portland	Jay	Stump, Thomas A.	Indianapolis	Marion
Steigmeyer, David J.	Fort Wayne	Allen	Stumpf, Edwin E.	New Haven	Allen
Stein, Richard H.	Vincennes	Knox	Stuntz, Edgar C.	Lafayette	Tippecanoe
Steinem, Joseph L.	Connersville	Fayette-Franklin	Sturgis, Donald G.	Sellersburg	Clark
Steinkamp, Emil F. (S)	Huntingburg	Dubois	Suelzer, John G.	Indianapolis	Marion
Steinmetz, Edward F.	Indianapolis	Marion	Sugarman, Benjamin E.	French Lick Springs	Orange
Stephens, Donald E.	Indianapolis	Marion	Sullenger, Adron A.	Vincennes	Knox
Stephens, James P.	Greencastle	Putnam	Sullivan, John M.	Terre Haute	Vigo
Stephens, Kehrman H.	Indianapolis	Marion	Sullivan, Robert E.	Fort Wayne	Allen
Stephens, Lowell R.	Covington	Fountain-Warren	Summerlin, Jack D.	Indianapolis	Marion
Stepleton, John D.	Richmond	Wayne-Union	Sutnick, Alton I.	Indianapolis	Marion
Stern, Mona K.	East Gary	Lake	Sutton, William E.	Indianapolis	Marion
Stern, Samuel L.	Hammond	Lake	Suzuki, Tsutomu T.	Covington	Fountain-Warren
Sterne, John H.	Evansville	Vanderburgh	Swan, John R.	Indianapolis	Marion
Steury, Ernest M.	Kenya Colony, B. E. Africa	Marion	Swan, Richard C.	Anderson	Madison
Steussy, Calvin N.	New Castle	Henry	Swank, Lucretia	Elkhart	Elkhart
Stevens, Edwin W.	Hammond	Lake	Sweany, Stanford	Hammond	Lake
Stevens, Sydney L.	Indianapolis	Marion	Sweeney, Robert M.	Indianapolis	Marion
Stewart, J. Frank W.	Vincennes	Knox	Sweet, Howard E.	Richmond	Wayne-Union
Stewart, L. Ray	Indianapolis	Marion	Swihart, Danny D.	Elkhart	Elkhart
Stewart, Walter E. (S)	Terre Haute	Vigo	Swihart, Homer R.	Elkhart	Elkhart
Stewart, William R.	Boonville	Warrick	Symmes, Alfred T.	Indianapolis	Marion
Stibbins, Warren E.	Muncie	Delaware-Blackford	Symon, William E.	Bluffton	Wells
Stier, Paul L.	Fort Wayne	Allen	Szumilas, Peter P.	Cheyenne, Wyo.	Marion
Stillwell, William R.	Richmond	Wayne-Union	Szynal, John S.	Indianapolis	Marion
Stimson, Harry R.	Gary	Lake			
Stine, Marshall E.	Bremen	Marshall			
Stinson, Dean K.	Rochester	Fulton	Tabaka, Francis B.	La Porte	La Porte
Stinson, William M.	Anderson	Madison	Tager, Stephen N.	Evansville	Vanderburgh
Stiver, Daniel D.	South Bend	St. Joseph	Takahashi, Masato	Indianapolis	Marion
Stoelting, J. Lewis	Terre Haute	Vigo	Talarico, Leonard H.	Rochester, N. Y.	Marion
Stoelting, Vergil K.	Indianapolis	Marion	Talbert, Pierre C.	Bluffton	Wells
Stogdill, William J.	South Bend	St. Joseph	Talbott, Dan E.	Indianapolis	Marion
Stogsdill, Willis W.	Franklin	Johnson	Tan, Constancio C.	Newport News, Va.	Miami
Stoltz, Robert M.	Valparaiso	Porter	Tanner, Henry S.	Indianapolis	Marion
Stone, Alvin T.	Indianapolis	Marion	Taraba, Ralph W.	Bloomington	Owen-Monroe
Stone, Robert C.	Ligonier	Noble	Tate, Elizabeth	Dunkirk	Jay
Stoops, Jean T.	Wabash	Wabash	Taub, Robert G.	Michigan City	La Porte
Storey, D. Edmund	Indianapolis	Marion	Taube, Jack I.	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion	Taylor, Clifford C.	Indianapolis	Marion
Stork, Harvey K.	Huntingburg	Dubois	Taylor, Cyril	Indianapolis	Marion
Stork, Urban	Evansville	Vanderburgh	Taylor, Donald J.	Terre Haute	Vigo
Storms, Roy B. (S)	Indianapolis	Marion	Taylor, Donald R.	Muncie	Delaware-Blackford
Stouder, Albert E.	Kepton	Tipton			
Stouder, Charles E.	Ellettsville	Owen-Monroe	Taylor, Everett C.	Upland	Grant
Stout, Francis E.	Muncie	Delaware-Blackford	Taylor, Frederic W.	Indianapolis	Marion
			Taylor, James A.	Muncie	Delaware-Blackford
Stout, Harry T.	Frankfort	Clinton			
Stout, Walter M. (S)	New Castle	Henry	Taylor, John R.	Palestine, Ill.	Sullivan

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Name	City	County	Name	City	County
Taylor, M. Reed, Jr.	South Bend	St. Joseph	Tindall, William R.	Shelbyville	Shelby
Taylor, Max T.	Fort Benning, Ga.	Marion	Tinney, William E. (S)	Pass-A-Grille, Fla.	Marion
Taylor, Robert G.	Fort Wayne	Allen	Tinsley, Frank W.	Indianapolis	Marion
Taylor, Wade H. (S)	Ambia	Benton	Tinsley, Walter B. (S)	Indianapolis	Marion
Taylor, William R.	Richmond	Wayne-Union	Tinsley, Walter B., Jr.	Indianapolis	Marion
Teague, Frank W.	Indianapolis	Marion	Tipton, William R.	Greencastle	Putnam
Teal, Dorothy D.	Columbus	Bartholomew-Brown	Tirman, Wallace S.	South Bend	St. Joseph
Tedford, John H.	Ann Arbor, Mich.	Clinton	Tischer, E. Paul	Indianapolis	Marion
Teegarden, Joseph A. (S)	East Chicago	Lake	Tisserand, John B. Jr.	Evansville	Vanderburgh
Teegarden, Joseph A., Jr.	East Chicago	Lake	Todd, David D. (S)	LaJolla, Calif.	Elkhart
Teixler, Victor A.	Indianapolis	Marion	Tomak, Milton E.	Linton	Greene
Templeton, Ames R.	Mishawaka	St. Joseph	Tomlin, Hugh M.	Muncie	Delaware-Blackford
Templeton, Ian S.	Seymour	Jackson	Tomusk, August N.	Fort Wayne	Allen
Templin, David B.	Lowell	Lake	Tondra, John M.	Indianapolis	Marion
Tennant, David L.	Fort Wayne	Allen	Topoglus, James N.	Bloomington	Owen-Monroe
Tennis, George T.	Greencastle	Putnam	Topping, Malachi C.	Terre Haute	Vigo
Tepfer, Milton	Indianapolis	Marion	Torella, Jose A.	Indianapolis	Marion
Teplinsky, Louis L.	East Chicago	Lake	Tosick, William A.	Indianapolis	Marion
Terbush, Edward L.	Twelve Mile	Cass	Toumey, Fred L.	Indianapolis	Marion
Terrill, Richard W.	Fort Wayne	Allen	Tower, James H., Jr.	Shelbyville	Shelby
Terry, Lloyd	Danville	Hendricks	Tower, Thomas K.	Campbellsburg	Washington
Terry, Robert H.	Boonville	Warrick	Trachtenberg, Lee	Hammond	Lake
Terveer, John B.	Decatur	Adams	Tranter, William F.	Sharpsville	Tipton
Test, Charles E.	Indianapolis	Marion	Traver, Perry C. (S)	South Bend	St. Joseph
Teter, George V.	Indianapolis	Marion	Travis, Floyd D.	Shelbyville	Shelby
Teters, Melvin S.	Middlebury	Elkhart	Tremain, Milton A. (S)	Adams	Decatur
Tether, Joseph E.	Indianapolis	Marion	Treon, James F. (S)	Aurora	Dearborn-Ohio
Tetrick, Lain	Valparaiso	Porter	Trepagnier, Francis B.	E. Chicago	Lake
Tharpe, Ray G.	Indianapolis	Marion	Trimble, John G.	Kokomo	Howard
Thatcher, Hugh K., Jr.	Indianapolis	Marion	Trinosky, Frank G.	Gary	Lake
Thayer, Benet W.	North Vernon	Jennings	Trout, Carl J.	Lafayette	Tippecanoe
Theobald, Sterling	Dyer	Lake	Troutwine, William R.	Crown Point	Lake
Thimlar, James W. (S)	Fort Wayne	Allen	Troy, Jack M.	Whiting	Lake
Thom, Julia S.	Terre Haute	Vigo	Troyer, Dana	Goshen	Elkhart
Thomas, Charles R.	Indianapolis	Marion	Troyer, George W.	Elkhart	Elkhart
Thomas, Daniel D.	Gary	Lake	Trusler, Harold M.	Indianapolis	Marion
Thomas, Edward P.	Indianapolis	Marion	Tsatsos, George C.	Gary	Lake
Thomas, Everett W.	Warsaw	Kosciusko	Tschetter, David J.	Indianapolis	Marion
Thomas, Fred A.	Indianapolis	Marion	Tubbs, George R. (S)	Lafayette	Tippecanoe
Thomas, Gerald I.	Gary	Lake	Tuchman, Joseph H.	Indianapolis	Marion
Thomas, Lowell J.	Indianapolis	Marion	Tucker, Oral A.	Daleville	Delaware-Blackford
Thomas, Morris E.	Indianapolis	Marion	Tucker, Warren S.	Indianapolis	Marion
Thomas, Thomas R.	Hammond	Lake	Tuholski, James M.	Evansville	Vanderburgh
Thomas, W. Clayton	Carmel	Hamilton	Tully, John A. (S)	New Castle	Henry
Thompson, Alfred A. (S)	Tyner	Marshall	Tunnell, Harry D.	Michigan City	La Porte
Thompson, B. Jay	Marion	Grant	Turgi, Robert W.	Gary	Lake
Thompson, Claude N.	Waynetown	Montgomery	Turley, Verne L.	Fowler	Benton
Thompson, Frank M.	Columbia City	Whitley	Turner, Anna Goss	Madison	Jefferson-Switzerland
Thompson, Holland	Fort Wayne	Allen	Turner, Harold B. (S)	Bloomfield	Greene
Thompson, John M.	South Bend	St. Joseph	Turner, Isabel B.	Evansville	Vanderburgh
Thompson, John V.	Indianapolis	Marion	Turner, Jack J.	Bloomfield	Greene
Thompson, Joseph F.	Indianapolis	Marion	Turner, John P.	Goshen	Elkhart
Thompson, Naiad Mason	Evansville	Vanderburgh	Turner, Oscar A. (S)	Madison	Jefferson-Switzerland
Thompson, Paul D.	Indianapolis	Marion	Tweedall, Daniel C.	Evansville	Vanderburgh
Thompson, Robert A.	South Bend	St. Joseph	Tyler, Edward A.	Indianapolis	Marion
Thompson, Walter	Jeffersonville	Clark	Tyler, Frank T. (S)	New Albany	Floyd
Thompson, Wayne H.	Indianapolis	Marion	Tyner, Harlan H.	Indianapolis	Marion
Thompson, Wm. R.	Winamac	Pulaski	Tyrrell, Joseph J.	Calumet City, Ill.	Lake
Thornburg, Kenneth E.	Indianapolis	Marion	Tyrrell, Thomas C.	Calumet City, Ill.	Lake
Thorne, Charles E.	New Castle	Henry		U	
Thornton, Harold C.	Indianapolis	Marion	Ullom, Ralph B.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph	Ulrey, Robert P.	Elwood	Madison
Thrasher, John R. (S)	New Augusta	Marion	Underwood, George M.	Lafayette	Tippecanoe
Throop, Frank B.	Indianapolis	Marion	Urschel, Dan L.	Mentone	Kosciusko
Thurstun, Harrison S. (S)	Dayton, Ohio	Marion			
Tilden, Margaret H.	Evansville	Vanderburgh			
Tiley, George A.	Greenwood	Johnson			
Tilka, Edward C.	Hammond	Lake			
Tindall, George T.	Indianapolis	Marion			
Tindall, Paul R. (S)	Shelbyville	Shelby			

Name	City	County	Name	City	County
V					
Vagner, S. Bernard	South Bend	St. Joseph	Wagner, Richard	Huntington	Huntington
Valencia, M. M.	Gary	Lake	Wagoner, B. D.	Union City	Randolph
Van Bokkelen, Robert W.	Mooresville	Morgan	Wagoner, George W.	Delphi	Carroll
Van Buskirk, Edmund L.	Lafayette	Tippecanoe	Wagoner, John R.	Anderson	Madison
Vance, William C.	Richmond	Wayne-Union	Wainscott, Clinton S.	Indianapolis	Marion
Van Den Bosch, Wallace R.	Lafayette	Tippecanoe	Wait, Jerome H.	Columbia City	Whitley
Vandivier, Robert M.	Indianapolis	Marion	Waits, Chester L.	Colfax	Clinton
Van Dorn, Myron J.	Indianapolis	Marion	Waitt, Paul M.	Sheridan	Hamilton
Van Fleet, Josephine	Indianapolis	Marion	Waldo, Guy H.	Bedford	Lawrence
Van Kirk, John R.	Burlington	Carroll	Waldo, J. Thayer	Indianapolis	Marion
Van Kirk, Paul P.	Frankfort	Clinton	Walerko, Frank	Mishawaka	St. Joseph
Van Meter, C. Powell	Indianapolis	Marion	Walker, Adolph P.	East Chicago	Lake
Van Ness, William C.	Summitville	Madison	Walker, Edwin M., Jr.	South Bend	St. Joseph
VanNest, Willard A.	New Smyrna Beach, Fla.	De Kalb	Walker, Floyd B.	Fort Wayne	Allen
Van Nuys, John D.	Indianapolis	Marion	Walker, Jack M.	Muncie	Delaware-Blackford
Van Rie, Leo P. (S)	Mishawaka	St. Joseph	Walker, James L. (S)	LaFontaine	Wabash
Van Sandt, Frank A. (S)	Bloomfield	Greene	Walker, Louis	Greensburg	Decatur
Van Tassel, Charles J.	Indianapolis	Marion	Walker, Robert K.	Indianapolis	Marion
Van Vactor, Helen D.	Indianapolis	Marion	Walker, William F.	Evansville	Vanderburgh
Van Wienen, John	Martinsville	Morgan	Wallace, Collins R.	Fort Knox, Ky.	Marion
Vaughn, Walter R.	Vincennes	Knox	Wallace, Elmer L.	New Albany	Floyd
Veach, Lester W.	Bainbridge	Putnam	Wallace, Hawthorne C.	Crawfordsville	Montgomery
Veach, William L.	Terre Haute	Vigo	Walter, Paul A. F. III	Evansville	Vanderburgh
Veach, Richard L.	Bainbridge	Putnam	Walter, Robert F.	Evansville	Vanderburgh
Vellios, Frank	Indianapolis	Marion	Walters, Charles E.	Mishawaka	St. Joseph
Venable, George L.	North Manchester	Wabash	Walters, Eleanor	Gary	Lake
Venis, Kemper N.	Muncie	Delaware-Blackford	Walters, Jack	Franklin	Johnson
Vermilya, Robert W.	Lafayette	Tippecanoe	Walters, William H.	Michigan City	La Porte
Verplank, Grover L. (S)	Gary	Lake	Walther, Joseph E.	Indianapolis	Marion
Viehe, Robert W.	Evansville	Vanderburgh	Walton, R. Lee	Marion	Grant
Vietzke, Paul C. F.	Valparaiso	Porter	Walton, William M.	Indianapolis	Marion
Vingis, Bronie	Greenfield	Hancock	Wanninger, Horace	Richmond	Wayne-Union
Viney, Charles L.	Logansport	Cass	Warbinton, Fred P.	Plainfield	Hendricks
Visher, John W.	Evansville	Vanderburgh	Ward, Gerald F.	Fort Wayne	Allen
Vivian, Donald E.	New Castle	Henry	Ward, James W.	South Bend	St. Joseph
Vogel, John L.	Columbia City	Whitley	Ward, Paula B.	Fort Wayne	Allen
Vogel, Lloyd A., Jr.	Fort Wayne	Allen	Ward, Wesley C.	Indianapolis	Marion
Vogel, L. John	Mount Vernon	Posey	Ware, Herbert E.	Muncie	Delaware-Blackford
Voges, Edward C.	Terre Haute	Vigo	Ware, John R.	Russiaville	Howard
Vollrath, Victor J.	Indianapolis	Marion	Warfield, Chester H.	Fort Wayne	Allen
VonAsch, George	La Porte	La Porte	Warman, Alvah P. (S)	Indianapolis	Marion
von der Lieth, Wm. C.	Vincennes	Knox	Warn, William J.	Milan	Ripley
Von Der Haar, Gerard	Indianapolis	Marion	Warneke, Charles H.	Indianapolis	Marion
vonder Haar Thomas E.	Evansville	Vanderburgh	Warner, Charles L.	Evansville	Vanderburgh
Voorhees, Robert J.	Clayton, Mo.	Allen	Warren, Carroll B.	Marion	Grant
Voorhies, McKinley	Gary	Lake	Warren, Lewis T.	Michigan City	La Porte
Vore, Hugh A.	Highland	Lake	Warrick, Francis B.	Richmond	Wayne-Union
Vore, Louring W.	Plymouth	Marshall	Warrick, Homer L.	Osceola	St. Joseph
Vore, Robert E.	Indianapolis	Marion	Warriner, James B.	Indianapolis	Marion
Voss, Gert	Muncie	Delaware-Blackford	Warshaw, Seymour	Columbus	Bartholomew-Brown
Voyles, Charles F. (S)	Indianapolis	Marion	Warvel, John H., Jr.	Indianapolis	Marion
Voyles, Harry E.	New Albany	Floyd	Warvel, John H.	Indianapolis	Marion
Vurpillat, Francis J.	South Bend	St. Joseph	Washington, G. Kenneth	Gary	Lake
Vye, James P.	Gary	Lake	Waters, George W.	Evansville	Vanderburgh
W			Watterson, Gerald T.	Connersville	Fayette-Franklin
Wachob, Tom W., Jr.	Kokomo	Howard	Waymire, William	Franklin	Johnson
Wack, James E.	South Bend	St. Joseph	Weaver, Richard J.	Lafayette	Tippecanoe
Wade, Alfred A. (S)	Howe	LaGrange	Weaver, Timothy M. (S)	Brazil	Clay
Wade, Reynolds W.	New Haven	Allen	Weaver, Wm. W.	New Albany	Floyd
Wagner, Anabel R.	Indianapolis	Marion	Webb, Harry D.	Anderson	Madison
Wagner, Arthur L.	Jasper	Dubois	Weber, Edgar H.	Evansville	Vanderburgh
Wagner, David G.	Goshen	Elkhart	Weber, John R.	Fort Wayne	Allen
Wagner, Lindley H.	Indianapolis	Marion	Weber, Joseph G. S.	Terre Haute	Vigo
			Webster, Paul L.	Indianapolis	Marion
			Webster, Robert K.	Brazil	Clay
			Weddle, Chas. O.	Lebanon	Boone

Name	City	County	Name	City	County
Weeks, Patrick H. (S)	Michigan City	La Porte	Wiland, Olin K.	Richmond	Wayne-Union
Weems, Mallory P.	Jeffersonville	Clark	Wilder, Gordon B.	Anderson	Madison
Wehrman, Jule O. (S)	Indianapolis	Marion	Wilhelm, Agatha M.	South Bend	St. Joseph
Weigand, Clayton G.	Indianapolis	Marion	Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Weinbaum, Jack G.	Terre Haute	Vigo	Wilhelmus, Charles M. (S)	Newburgh	Warrick
Weinberg, Benjamin A.	Whiting	Lake	Wilhelmus, Gilbert M.	Evansville	Vanderburgh
Weinberg, Samuel	Marion	Grant	Wilkens, Irvin W.	Indianapolis	Marion
Weinland, George C.	Columbus	Bartholomew-Brown	Wilkinson, Dudley E.	Martinsville	Morgan
Weinstein, Edwin B.	Richmond	Wayne-Union	Williams, A. Berniece	Fort Wayne	Allen
Weinstock, Adolph	Rolling Prairie	La Porte	Williams, Aubrey H.	Fort Wayne	Allen
Weir, Dale	Louisville, Ky.	LaGrange	Williams, Alexander S.	Gary	Lake
Weirich, Charles I.	Butler	De Kalb	Williams, Charles D.	Indianapolis	Marion
Weisenberger, Brockton L.	Lawrenceburg	Dearborn-Ohio	Williams, Clifford L.	Indianapolis	Marion
Weiskopf, Henry S.	Gary	Lake	Williams, Earl K.	Columbus	Bartholomew-Brown
Weiss, Albert E.	Michigan City	LaPorte	Williams, Edwin D.	Gary	Lake
Weiss, Eugene	South Bend	St. Joseph	Williams, Everett W.	Columbus	Bartholomew-Brown
Weiss, Henry G.	Evansville	Vanderburgh	Williams, Francis M.	Anderson	Madison
Weiss, Jason	Indianapolis	Marion	Williams, Fred	Gary	Lake
Weiss, John T.	Hobart	Lake	Williams, Fielding P.	Huntingburg	Dubois
Weiss, Louis L.	Anderson	Madison	Williams, Harold W.	Indianapolis	Marion
Weissman, Charles G.	Hammond	Lake	Williams, Howard S.	Indianapolis	Marion
Weitemier, Raymond A.	Richmond	Wayne-Union	Williams, Hugh L.	Indianapolis	Marion
Weitzel, Roland E.	Princeton	Gibson	Williams, John H.	Shipshewana	LaGrange
Welborn, Mell B.	Evansville	Vanderburgh	Williams, Paul A.	Rensselaer	Jasper-Newton
Welch, Norbert M.	Vincennes	Knox	Williams, Paul D.	Indianapolis	Marion
Weldy, Bryce P.	Hartford City	Delaware-Blackford	Williams, Robert D.	Markleville	Madison
Weller, Charles A. (S)	Indianapolis	Marion	Williams, Robert E.	Lafayette	Tippecanoe
Weller, Ralph D.	Rossville	Clinton	Williams, Robert H.	Anderson	Madison
Wells, William R.	Princeton	Gibson	Williams, Russell S.	Lafayette	Tippecanoe
Wenzler, Paul J.	Bloomington	Owen-Monroe	Willis, Charles F.	Evansville	Vanderburgh
Werry, Leslie E.	Hartford City	Delaware-Blackford	Willison, George W.	Evansville	Vanderburgh
Wertemberger, Morris D.	Richmond	Wayne-Union	Willits, Bruce K.	Norfolk, Va.	Marion
West, Joseph L.	Indianapolis	Marion	Willner, Alan	Clarksville	Clark
Westfall, B. Kemper	Indianapolis	Marion	Wills, Max	Auburn	De Kalb
Westfall, George S.	Goshen	Elkhart	Wilmore, Ralph C.	Indianapolis	Marion
Westfall, John B.	Indianapolis	Marion	Wilms, John H.	W. Lafayette	Tippecanoe
Westhaysen, Peter V.	Munster	Lake	Wilson, David	Evansville	Vanderburgh
Wharton, Russell O. (S)	Gary	Lake	Wilson, Fred L.	Terre Haute	Vigo
Wheeler, David E.	Indianapolis	Marion	Wilson, Fred M.	Indianapolis	Marion
Whipps, Charles E. (S)	Carlisle	Sullivan	Wilson, Guy H.	Bicknell	Knox
Whisler, Frederick M. (S)	Wabash	Wabash	Wilson, James M.	South Bend	St. Joseph
Whitcomb, Roger F.	Shelbyville	Shelby	Wilson, John	Columbia City	Whitley
White, Chester S. (S)	Rosedale	Parke-Vermillion	Wilson, John D.	Evansville	Vanderburgh
White, Donald G.	South Bend	St. Joseph	Wilson, Leslie	Fort Wayne	Allen
White, Donald J.	Indianapolis	Marion	Wilson, Ned A.	Indianapolis	Marion
White, Douglas H.	Indianapolis	Marion	Wilson, Oliver R.	Indianapolis	Marion
White, Gilbert H., Jr.	Hammond	Lake	Wilson, Orley E.	Elkhart	Elkhart
White, Harvey E.	Farmland	Randolph	Wilson, Paul E. (S)	Boonville	Warrick
White, Isaac D. (S)	Clinton	Parke-Vermillion	Wilson, Paul H.	Logansport	Cass
White, James V.	Terre Haute	Vigo	Wilson, Ralph	Evansville	Vanderburgh
White, John B.	Indianapolis	Marion	Wilson, Roland B.	Fort Wayne	Allen
White, Nicholas	Indianapolis	Marion	Wilson, Talmage L.	Bloomington	Owen-Monroe
White, Philip T.	Indianapolis	Marion	Wilson, Wymond B.	Mentone	Kosciusko
Whitlock, Francis C.	Mishawaka	St. Joseph	Wimmer, Robert N. (S)	Gary	Lake
Whitlock, Merle E.	Mishawaka	St. Joseph	Winklepleck, A. M.	Connersville	Fayette-Franklin
Wiatt, Leonard H.	Knightstown	Henry	Winter, Donald K.	Logansport	Cass
Wible, James H.	Kokomo	Howard	Winter, William P.	Martinsville	Morgan
Wick, Alfred A.	Fort Wayne	Allen	Wirey, Harold R.	Indianapolis	Marion
Wickstrom, Otto W.	Indianapolis	Marion	Wise, Charles L.	Camden	Carroll
Widdifield, G. E.	Indianapolis	Marion	Wise, William R.	Indianapolis	Marion
Wiedemann, Frank E. (S)	Terre Haute	Vigo	Wiseheart, Oscar H. (S)	North Salem	Hendricks
Wierzalis, Edward F.	Hartford City	Delaware-Blackford	Wiseheart, Robert H.	Lebanon	Boone
Wiethoff, Clifford A.	Seymour	Jackson	Wiseman, V. Earle	Greencastle	Putnam
Wiggins, Dulanis S. (S)	Newcastle	Henry	Wishard, Wm. N., Jr.	Indianapolis	Marion
			Witham, Robert L.	Indianapolis	Marion
			Witt, William R.	Jeffersonville	Clark
			Wixted, John F.	South Bend	St. Joseph
			Wixted, Julia F.	South Bend	St. Joseph

Name	City	County	Name	City	County
Wohlfeld, Gerald	Indianapolis	Marion	Yocum, Paul S.	Gary	Lake
Wohlfeld, Julius B.	Bedford	Lawrence	Yocum, Paul S., Jr.	Gary	Lake
Wojcik, Ladislav D.	Marion	Grant	Yocum, William S.	Gary	Lake
Wolfe, William E.	La Porte	La Porte	Yoder, Albert C. (S)	Goshen	Elkhart
Wolfe, Morton F.	Clarksville	Clark	Yoder, C. Richard	Elkhart	Elkhart
Wolfe, Nelson	New Albany	Floyd	Yoder, Dewey D.	Pierceton	Kosciusko
Wolfram, Don J.	Indianapolis	Marion	Yoder, Richard P.	Bluffton	Wells
Wolverton, George M.	Clarksville	Clark	Young, C. Curtis	Evansville	Vanderburgh
Woner, John W.	Linton	Greene	Young, George M.	Gary	Lake
Wong, Norman F.	Linden	Montgomery	Young, Gerald S.	Muncie	Delaware- Blackford
Wong, Samuel N.	Hammond	Lake			
Wood, Donald E.	Indianapolis	Marion	Young, James W.	Indianapolis	Marion
Wood, Opal L.	Brazil	Clay	Young, John E.	Indianapolis	Marion
Woodard, Abram S., Jr.	Indianapolis	Marion	Young, John M.	Indianapolis	Marion
Woodbury, John W.	Marion	Grant	Young, John T.	Indianapolis	Marion
Wooden, Thomas F.	East Chicago	Lake	Young, Joseph	Greenwood	Johnson
Woods, Arba L. (S)	Evansville	Vanderburgh	Young, Ralph H.	Goshen	Elkhart
Woods, Haldon C.	Markle	Huntington	Young, Robert G.	Marion	Grant
Woods, James R., Jr.	Greenfield	Hancock	Young, Robert L.	Gary	Lake
Woods, Wm. P. (S)	Evansville	Vanderburgh	Yunker, Philip E.	Howe	LaGrange
Woodson, Dan E.	Boonville	Warrick			
Woolery, Richard H.	Bedford	Lawrence		Z	
Woolling, Kenneth R.	Indianapolis	Marion	Zalac, Donald A.	Michigan City	La Porte
Work, Bruce A.	Frankfort	Clinton	Zallen, Stanley G.	East Chicago	Lake
Work, James A., Jr. (S)	Elkhart	Elkhart	Zaring, Byron K.	Columbus	Bartholomew- Brown
Worley, Ansel C.	Fort Wayne	Allen			
Worley, Henry L.	New Albany	Floyd	Zehr, Noah (S)	Fort Wayne	Allen
Worley, Joseph P.	Indianapolis	Marion	Zeiger, Irvin	South Bend	St. Joseph
Worley, Richard H.	Indianapolis	Marion	Zeitler, Philip S.	Elkhart	Elkhart
Worth, C. Willard	Milroy	Rush	Zell, Evertson H.	Indianapolis	Marion
Wrege, Malcolm L.	Indianapolis	Marion	Zeps, E. Frances	Richmond	Wayne-Union
Wright, Cecil S.	Anderson	Madison	Zerfas, Charles P. A.	Beech Grove	Marion
Wright, J. Wm., Jr.	Indianapolis	Marion	Zerfas, Leon G.	Camby	Marion
Wright, Wm. C.	Fort Wayne	Allen	Zerfas, Phyllis K.	Indianapolis	Marion
Wurster, Herbert C.	Mishawaka	St. Joseph	Zeier, Francis G.	Evansville	Vanderburgh
Wyatt, James L., III	Fort Wayne	Allen	Zierer, Reuben O.	Rockville	Parke- Vermillion
Wyeth, Charles (S)	Terre Haute	Vigo			
Wygant, Marion D.	Westville	La Porte	Zimmer, Henry J.	Mishawaka	St. Joseph
Wynegar, David E.	Richmond	Wayne-Union	Zimmerman, Harold	Evansville	Vanderburgh
Wynn, Justice F.	Evansville	Vanderburgh	Zimmerman, Wm. H.	Syracuse	Kosciusko
Wynne, Roland E. (S)	Bedford	Lawrence	Zink, Robert O.	Madison	Jefferson- Switzerland
Wytenbach, John E.	Indianapolis	Marion			
	Y		Ziperman, H. Haskell	San Fran- cisco, Calif.	Marion
Yacko, Michael L.	Indianapolis	Marion			
Yale, Charles A.	Fairmount	Grant	Ziss, Robert C.	Evansville	Vanderburgh
Yanson, Mannfredo R. S.	East Chicago	Lake	Zore, Joseph J.	Indianapolis	Marion
Yast, Charles J.	Gary	Lake	Zucker, Edward	Gary	Lake
Yegerlehner, Roscoe S.	Kentland	Jasper- Newton	Zweig, Elmer S.	Fort Wayne	Allen
			Zwerner, Paul F.	Terre Haute	Vigo
Yingling, Robert J.	Key West, Fla.	Marion	Zwick, Harold F.	Decatur	Adams
			Zwickel, Ralph E.	Evansville	Vanderburgh

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid-up members of the Indiana State Medical Association as of May 1, 1961.)

ADAMS COUNTY

Berne

Beaver, Norman E. 165 W. Water St.
Bixler, James A. 165 N. Jefferson St.
Boze, Robert L. 265 W. Water St.
Luginbill, Howard M. 165 S. Jefferson St.

Decatur

Burk, James M. 115 N. Third St.
Carrol, John C. 226 S. Second St.
Freeby, C. William. 227 S. Second St.
Girod, Arthur H. 203 N. Twelfth St.
Kohne, Gerald J. 134 S. Third St.
Parrish, Richard K. 238 S. Second St.
Reppert, Roland L. 222 S. Second St.
Rich, Norval. 415 W. Madison St.
Terveer, John B. 222 S. Second St.
Zwick, Harold F. 227 S. Second St.

Schetgen, Joseph V. Geneva

ALLEN COUNTY

Fort Wayne

A

Adams, E. Wade. 710 W. Wayne
Ahlbrand, Roland C. 1417 N. Anthony Blvd.
Aiken, Arthur F. 1923 E. State Blvd.
Aiken, Nevin E. 1923 E. State Blvd.
Arata, Justin E. 304 Medical Center Bldg.

B

Bahr, Robert E. 533 W. Washington St.
Bailey, Paul P. 206 Medical Center Bldg.
Ball, John R. 320 Medical Center Bldg.
Ball, Margaret J. 4112 S. Harrison Blvd.
Baltes, Joseph H. 821 Broadway
Barch, John W. 1301 S. Harrison St.
Bash, Wallace E. 2424 Fairfield Ave.
Baumgartner, Jeraldine. 515½ W. Wayne St.
Beams, Ralph H. 715 Medical Center Bldg.
Beierlein, Karl M. 446 W. Pontiac
Bergendahl, Emil H. 102 Medical Center Bldg.
Berghoff, James R. 306 E. Jefferson St.
Berghoff, Raymond J. 306 E. Jefferson St.
Beutler, Theodore V. 527 W. Berry St.
Blichert, Peter A. 334 Medical Center Bldg.
Blosser, Howard V. (S) 1122 W. Washington Blvd.

Bolman, Ralph M. 717 Broadway
Bossard, John W. 115 Medical Center Bldg.
Bowers, Gah T. 1417 N. Anthony Blvd.
Bowers, Jesse W. (S) 418 Gettle Bldg.
Brandt, William E. 228 Medical Center Bldg.
Bridges, William L. 520 Medical Center Bldg.
Bromley, Luman W. 2730 E. State St.
Brosius, Robert H. W. 1603 Wells St.
Brown, Frederic W. 2609 Fairfield Ave.
Bryan, Franklin A. 512 Medical Center Bldg.
Buckner, George D. 1003 Fulton St.

C

Carlo, Ernest R. 2902 Fairfield Ave.
Cartwright, Emor L. (S) 3718 Hiawatha Blvd.
Chambers, Alan R. 601 W. Wayne St.
Chase, James A. 1635 Broadway

Clark, William R. 3622 S. Calhoun St.
Cochran, Harry A., Jr. 1301 S. Harrison St.
Conley, John E. 620 W. Berry St.
Connelly, Richard D. 810 Lake Ave.
Cooney, Charles J. 527 W. Berry St.
Cottrell, Robert F. 234 Medical Center Bldg.
Craig, Richard M. 2902 Fairfield Ave.
Culp, John E. 2902 Fairfield Ave.

D

Datzman, Richard C. 520 Medical Center Bldg.
Davidoff, Manuel A. 3610 Brooklyn Ave.
Ditton, Irvin W. (S) 1214 E. Wayne St.
Duemling, Arnold H. 6526 Upper Huntington Rd.
Dunstone, Harry C. 502 Medical Center Bldg.

E

Elston, Lynn W. 604 Medical Center Bldg.
Elston, Ralph W. 604 Medical Center Bldg.
Emenhiser, John L. 1411 Reed Rd.

F

Farquhar, John S. 4349 S. Anthony Blvd.
Ferguson, Arthur N. 2902 Fairfield Ave.
Fichman, Abraham M. 323 W. Berry St.
Flaherty, Robert A. 2902 Fairfield Ave.
Foy, Hayward W. 1747 Wells St.
Franke, Gordon R. 1202 E. State Blvd.
Frankhouser, Charles M. A. 520 Medical Center Bldg.
Fullam, Richard G. 234 Medical Center Bldg.

G

Garton, Harry W. R. R. 6, Hamilton Rd.
Gastineau, David C. 520 Medical Center Bldg.
Gerding, William J. 2638 S. Anthony Blvd.
Gladstone, Naf H. 335 W. Berry St.
Glassley, Stephen H. 1923 E. State St.
Glock, Homer E. (S) 324 Medical Center Bldg.
Glock, Maurice E. 229 Medical Center Bldg.
Glock, Wayne R. 2609 Fairfield Ave.
Goebel, Carl W. 327 W. Creighton
Gould, John C. 612 Medical Center Bldg.
Graham, George M. 1301 S. Harrison St.
Graham, James C. 805 E. Creighton Ave.
Greenlee, Robert L. 1110 W. Washington Blvd.
Griest, Walter D. 3024 Fairfield Ave.
Griffith, Harold R. 520 Medical Center Bldg.

H

Hackett, Walter G. 6028 U. Huntington Rd.
Haffner, Herman G. 202 E. Jefferson St.
Haley, Alvin J. 533 W. Washington Blvd.
Haller, Richard C. 422 Medical Center Bldg.
Hamilton, Emory D. 234 Medical Center Bldg.
Hamilton, George M. 1416 N. Anthony Blvd.
Harshman, Louis P. Veterans Hospital
Harvey, Harry C. 406 W. Berry St.
Hasewinkle, August M. 1129 E. State St.
Hastings, Warren C. 815 Ewing St.
Hattendorf, Anton P. 725 Medical Center Bldg.
Havens, Russell E. 228 Medical Center Bldg.
Hershberger, Philip G. 2609 Fairfield Ave.
Hickman, Donald M. 3408 N. Anthony
Higgins, Kenneth E. 801 E. State St.

Hillery, Robert L.....810 W. State Blvd.
 Hipskind, Richard E.....332 E. Pontiac
 Hoffman, Arthur F.....519 Medical Center Bldg.
 Holsinger, Robert E.....115 Medical Center Bldg.
 Howe, Fordyce L.....1525 Oxford St.
 Humphreys, John L.....1301 S. Harrison St.

J

Jackson, John F.....519 Medical Center Bldg.
 Jontz, Joe G.....304 Medical Center Bldg.
 Jurgens, Richard B.....R. R. 13, Lima Road
 Jurgensen, Walter T.....3415 Fairfield Ave.

K

Karol, Herbert J.....324 Medical Center Bldg.
 Kaufman, Julian.....229 W. Berry St.
 Keck, Carleton A.....2902 Fairfield Ave.
 Kent, Richard N.....731 Medical Center Bldg.
 Keyes, Robert C.....3714 S. Calhoun
 Kidder, Orva T.....Irene Byron Hospital
 Kimbrough, Robert F.....2730 E. State St.
 Kleifgen, William A.....617 W. Washington Blvd.
 Klooze, Kenneth W.....3610 Brooklyn Ave.
 Knight, Lewis W.....446 W. Pontiac
 Krueger, John E.....204 E. Suttentfield
 Kruse, Edward H. (S).....705 Lincoln Tower
 Kruse, Walter E.....410 McKinnie

L

Ladig, Donald S.....337 W. Berry St.
 Lampe, Elfred H.....2902 Fairfield Ave.
 Land, Francis L.....4628 S. Calhoun
 Laycock, Richard M.....6642 St. Joe Road
 Leming, Ben L.....2902 Fairfield Ave.
 Lenk, George G.....1805 E. Washington St.
 Lloyd, Robert P.....723 Fulton St.
 Logan, Richard S.....347 W. Berry St.
 Lohman, Robert M.....4017 S. Wayne St.
 Lorman, James G.....520 Medical Center Bldg.
 Loudermilk, Jack L.....520 Medical Center Bldg.
 Lyon, William C.....710 W. Wayne St.

M

Mackel, Frederick O.....2609 Fairfield Ave.
 Manning, George C.....111 Medical Center Bldg.
 Marshall, Caesar L.....438 E. Lewis St.
 Mastrangelo, M. J.....717 Broadway
 McArdle, Edward G.....2201 S. Calhoun St.
 McCallister, John W.....212 Medical Center Bldg.
 McCoy, Roy R.....3701 S. Harrison St.
 McDowell, George A.....215 Medical Center Bldg.
 McEachern, Cecil G.....2424 Fairfield Ave.
 McKeeman, Donald H.....633 W. Wayne St.
 McKeeman, Leland S.....302 Medical Center Bldg.
 Mensch, James R.....2828 E. State St.
 Mercer, Samuel R.....702 Medical Center Bldg.
 Meyer, Herman A.....1030 W. Wayne St.
 Meyer, Theodore O.....622 Medical Center Bldg.
 Michaelis, Stephen C.....2154 Fairfield Ave.
 Miller, Edward D.....1402 E. State Blvd.
 Miller, H. Paul.....2715 Broadway
 Miller, Mahlon F.....222 Medical Center Bldg.
 Miller, Orval J.....324 W. Berry St.
 Miller, Richard H.....511 W. Wayne St.
 Miller, Robert B.....412 Medical Center Bldg.
 Miller, William J.....2902 Fairfield Ave.
 Moats, Carl F.....4007 S. Wayne St.
 Moats, George E. (S).....615 E. Washington Blvd.
 Moeller, Victor C.....2424 Fairfield Ave.
 Moravec, Arthur E.....705 Lincoln Tower
 Morey, Edwin E.....2902 Fairfield Ave.
 Mortenson, Leland J.....214 Medical Center Bldg.
 Mueller, Lawrence W.....533 W. Washington Blvd.
 Murdock, Harvey L.....417 Medical Center Bldg.

N-O

Nil, John H.....204 E. Suttentfield St.
 Nolan, Gerald R.....1626 Oxford St.
 O'Brian, John F.....1807 E. Washington Blvd.
 O'Rourke, Carroll.....604 W. Berry St.
 Oyer, John H.....2609 Fairfield Ave.

P

Painter, Donald S.....222 Medical Center Bldg.
 Parker, Carey B.....1105 S. Harrison St.
 Parrot, Donald J.....810 W. State St.
 Pauly, Leonard R.....730 W. Berry St.
 Pearson, Huey L.....1801 S. Hanna
 Perrin, Kermit F.....2701 S. Anthony Blvd.
 Perry, Frederic G.....2902 Fairfield Ave.
 Phelps, William J.....2828 E. State St.
 Pickett, Merle E.....228 Medical Center Bldg.
 Ponczek, Edward J.....3418 S. Hanna
 Popp, Milton F.....606 Medical Center Bldg.
 Powell, M. Jack.....730 W. Berry St.
 Priddy, Marvin E.....5010 Riviera Court

Q-R

Ray, Herbert A. (S).....402 Medical Center Bldg.
 Rice, Wilkie B. (S).....1101 E. Pontiac
 Rissing, Walter J.....229 W. Berry St.
 Rockey, Noah A.....1224 E. State
 Rodriguez, Juan.....2902 Fairfield Ave.
 Roser, Arthur J.....617 W. Washington Blvd.
 Rossiter, Dudley L.....3629 S. Harrison
 Rothberg, Maurice.....625 W. Berry St.
 Rousseau, John W.....446 W. Pontiac

S

Sahlmann, Hans.....3418 S. Hanna
 Salon, Harry W.....535 W. Berry
 Salon, Joel W.....604 W. Wayne St.
 Salon, Nathan L.....604 W. Wayne St.
 Sarver, Francis E.....320 Medical Center Bldg.
 Savage, Arthur R.....302 W. Berry St.
 Saylor, Rodger D.....R. R. #2
 Schlademan, Karl R.....520 Medical Center Bldg.
 Schloss, Robert P.....3504 Quimby Arcade
 Schmidt, Eugene E.....228 Medical Center Bldg.
 Schmoll, Robert J.....515 W. Wayne St.
 Schneider, Louis A.....730 W. Berry St.
 Schoen, Frederic L.....902 W. Wayne St.
 Schubert, Jerome C.....1320 Broadway
 Scoins, William H.....1301 S. Harrison St.
 Scott, H. Vaughn.....2902 Fairfield Ave.
 Senseny, Eugene F.....2902 Fairfield Ave.
 Shaw, James E.....3103 Bowser Ave.
 Sherwood, Clarence E.....Irene Byron Hospital
 Sherwood, J. Vincent.....Irene Byron Hospital
 Shinabery, Lawrence.....1850 Broadway
 Short, John T. (S).....2902 Fairfield Ave.
 Singer, Elmer C. (S).....310 Medical Center Bldg.
 Smith, Philip L.....2902 Fairfield Ave.
 Smith, Richard B.....629 Medical Center Bldg.
 Smith, Roger C.....629 Medical Center Bldg.
 Snyderman, Sanford C.....102 Medical Center Bldg.
 Somers, Gerald H.....2506 Lower Huntington Rd.
 Spencer, C. Herbert.....519 Medical Center Bldg.
 Stanley, Robert G.....3415 S. Fairfield Ave.
 Stauffer, Richard C.....2730 E. State St.
 Steigmeyer, David J.....1417 N. Anthony Blvd.
 Stier, Paul L.....721 Broadway
 Stucky, Jerry L.....5010 Riviera Court
 Sullivan, Robert E.....2424 Fairfield Ave.

T

Taylor, Robert G.....2902 Fairfield Ave.
 Tennant, David L.....1832 S. Calhoun
 Terrill, Richard W.....446 W. Pontiac

Thimlar, James W. (S).....602 E. Lewis
Thompson, Holland.....Irene Byron Hospital
Tomusk, August N.....717 Broadway

V-W

Vogel, Lloyd A., Jr.....4628 S. Calhoun
Walker, Floyd B.....3505 S. Monroe
Ward, Gerald F.....716 Medical Center Bldg.
Ward, Paula B.....2014 Curdes Ave.
Warfield, Chester H.....730 W. Berry St.
Weber, John R.....710 W. Wayne St.
Wick, Alfred A.....731 Medical Center Bldg.
Williams, A. Berniece.....3526 N. Washington Rd.
Wilson, Leslie.....Veterans Hospital
Wilson, Roland B.....1207 S. Lafayette
Worley, Ansel C.....317 Medical Center Bldg.
Wright, William C.....621 Medical Center Bldg.
Wyatt, James L., III.....310 E. Washington St.

X-Y-Z

Zehr, Noah (S).....301 W. Creighton
Zweig, Elmer S.....344 W. Berry St.

Emme, Richard W.....Harlan
Cutshaw, James A.....Monroeville
Harless, Fred.....Monroeville

New Haven

Dahling, Clemens W.....910 Summit
Emenhiser, Donald C.....608 State St.
Hoetzer, Eldore M.....502 Henry
Sidell, James P.....630 Broadway
Stumpf, Edwin E.....716 Broadway
Wade, Reynolds W.....1018 Bell Ave.

Miller, Kenneth D.....Woodburn
Moser, Edward (S).....Woodburn

Bichacoff, Billie D...860 N. Bush St., Ukiah, Calif.
Draper, Merlin H. (S)

59 Dolphin Dr., St. Petersburg, Fla. (6)

Helmer, Frederic A.

2057 Snowhill Dr., Cincinnati, Ohio

Mayes, Warren E....34 El Patio, Oakland 4, Calif.
Philbert, Richard N.

92 Avalon Dr., Daly City, Calif.

Prentiss, Nelson H....V. A. Hospital, Oteen, N. C.
Schellhouse, Earl M.

V.A. Hospital, Jefferson Barracks,
St. Louis, Mo.

Starr, Albert M....3215 W. 13th St., Erie, Pa.
Voorhees, Robert J...601 S. Brentwood, Clayton, Mo.

BARTHOLOMEW-BROWN COUNTIES**Columbus**

Able, Walter.....1919 25th St.
Adler, David L.....Bartholomew County Hospital
Beggs, Lowell F.....832 Washington St.
Biggs, William W.....Bartholomew Co. Hospital
Clay, Eleanor.....2739 Central Ave.
Daugherty, Forest D.....2438 Cottage Ave.
Davis, Marvin R.....908 Washington St.
Dugan, Thomas.....1813 25th St.
Echsner, Herman J.....1815 25th St.
Fisher, Walter S.....422 Ninth St.
Gammell, Lindley L.....602 22nd St.
Hart, Robert B.....712 Washington St.
Hawes, James K. (S).....P. O. Box 308
Hawes, Marvin E.....522 Seventh St.
Henry, Alvin L.....621 Franklin St.
Jacobs, E. Robert.....1919 25th St.
Knotts, Halleck S.....405½ Washington St.
Knotts, Slater....Bartholomew County Hospital
Krueger, Robert B.....2739 Central Ave.
Macy, George W.....718 Washington St.
Marr, Griffith.....R. R. 1
McCullough, Henry G.....R. R. 4
Mohler, Floyd W.....2739 Central Ave.

Norton, Harold J.....909 Pearl St.
O'Bryan, Richard B.....2739 Central Ave.
Overshiner, Lyman (S).....503 California
Ranck, Benjamin A.....2438 Cottage Ave.
Rau, Charles A.....1312 Audubon Dr.
Reid, Robert M.....2225 Central Ave.
Richmond, Harold W....Cummins Engine Co., Inc.
Ryan, William J.....911 Washington St.
Schmitt, Richard K.....423 Ninth St.
Sigmund, William B.....2355 Central Ave.
Snapp, Richard A.....2225 Central Ave.
Teal, Dorothy D.....728 Franklin St.
Warshaw, Seymour.....Charlotte Bldg.
Weinland, George C.....R. R. 5, Harrison Lake
Williams, Earl K.....Columbus
Williams, Everett W.....2225 Central Ave.
Zaring, Byron K.....718 Washington St.

Johnson, Robert B.....Hope
Schneider, Kenneth D.....Nashville
Seibel, Robert M.....Nashville

BENTON COUNTY

Taylor, Wade H. (S).....Ambia
Leak, Robert H.....Boswell
Coddens, Avery L.....Earl Park
Altier, William H.....Fowler
Miller, Dan T. (S).....Fowler
Turley, Verne L.....Fowler
Rutherford, Charles E.....Otterbein
Scheurich, Virgil.....Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Schaaf, Alvin D.....Jamestown

Lebanon

Beck, Herma A. (S)....Boone County Bank Bldg.
Coons, John D.....Boone County Bank Bldg.
Coons, Ritchie.....303 W. Washington St.
Grigsby, Hardin B.....916 N. East St.
Headley, Lloyd M.....1111 N. Lebanon St.
Honan, Paul R.....1720 N. Lebanon St.
Kern, Clarence G.....1720 N. Lebanon St.
Lenox, Jack.....303 W. Washington St.
Porter, Jack.....209 W. North St.
Rainey, Everett A. (S).....912 N. Meridian St.
Weddle, Charles O.....905 N. Lebanon St.
Wiseheart, Robert H.....905 N. Lebanon St.

Bassett, Margaret A.....Thorntown
Gregg, Edwin E.....Thorntown
Bailey, Lawrence S.....Zionsville
Harvey, Ralph J. (S).....Zionsville
Lovett, Harvey D.....Whitestown

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

Van Kirk, John R.....Burlington
Kennedy, Eva N. (S).....Camden
Wise, Charles L.....Camden

Delphi

Baker, Eldon E.....109 S. Union
Crampton, Charles C. (S).....115 E. Main St.
Petry, T. Neal.....111 E. Franklin St.

Seese, Robert M.....101 W. North St.
Wagoner, George W.....Front & Union Sts.

Adams, Max R.....Flora
McLaughlin, James R.....Flora

CASS COUNTY

Dutchess, C. Toney.....Galveston

Logansport

Adamski, Michael.....408 North St.
Bailey, Earl W.....212 Fifth St.
Ballard, Charles A (S).....325½ E. Market St.
Bean, Joseph S.....Memorial Hospital
Burnett, Paul C.....Logansport State Hosp.
Cheng, Sylvia F.....Logansport State Hosp.
Chu, Johnson C. S.....Logansport State Hosp.
Cobb, Clarence M.....Memorial Hosp.
Davis, John C. (S).....Masonic Temple
Eckert, Russell A.....1101 Michigan Ave.
Fitzgerald, Brice E.....126 Fourth St.
Fogel, Ernest.....Logansport State Hosp.
Gatzimos, Christos D.....1101 Michigan Ave.
Glendening, Richard L.....420 A High St.
Hall, Bernard R.....422 High St.
Harrington, James F.....1001 E. Broadway
Hedde, Eugene L.....211 S. Third St.
Hillis, Lowell J.....203 S. Third St.
Hochhalter, Marian.....86 9th St.
Holloway, William A. (S).....200 Eel River Ave.
Horning, Richard R.....Logansport State Hospital
Jewell, Earl B. (S).....3019 S. Pennsylvania St.
Jones, J. Carl.....422 North St.
King, Jay M.....201 S. Third St.
Mackey, Colonel G. (S).....Logansport State Hospital
Maschmeyer, Robert H.....Logansport State Hosp.
Mikan, V. Robert.....216 9th St.
Morrical, Russell J.....212 Fifth St.
Parker, E. Camille.....2500 E. Broadway
Parker, Francis W., Jr.....2500 E. Broadway
Pfuetze, Max.....408 North St.
Phipps, Elwood B.....Logansport State Hosp.
Schenck, Foss (S).....Logansport State Hosp.
Viney, Charles L.....Masonic Temple
Wilson, Paul H.....422 North St.
Winter, Donald K.....422 North St.

Newcomb, William K.....Royal Center
Terbush, Edward L.....Twelve Mile
Flanagan, Estle P. (S).....Walton
Lybrook, Daniel E. (S).....Young America

CLARK COUNTY

Goodman, Eli S.....Charlestown
Jones, David H.....Charlestown
Marshall, Thomas J. (S).....Charlestown
Marshall, Thomas R.....Charlestown
Shina, Heskell S.....Charlestown
Mudd, Joseph P.....Clarks ville
Willner, Alan.....Clarks ville
Wolfe, Morton F.....Clarks ville
Wolverton, George M.....Clarks ville
Carr, Joseph H.....Henryville
Greene, William R.....Henryville

Jeffersonville

Adair, Samuel.....201 E. Market
Baldwin, John H. (S).....425 Meigs Ave.
Bizer, Mier.....119 Forest, Oak Park
Bruner, Ralph W. (S).....437 Spring St.
Buehler, George M.....431 Locust St.
Byrd, Ryland P.....210 Sparks Ave.
Carlberg, Dale L.....226 E. Maple

Carney, Joel T.....347 Spring St.
Clark, William B., Jr.....437 Spring St.
Dare, Lee A.....209 E. Maple St.
Forsee, Norman E.....211 E. Market St.
Havens, A. Lyle.....432 Wall St.
Havens, Thomas R.....432 Wall St.
Huoni, John S.....1405 Youngstown Shopping Center
Isler, Nathaniel C.....519 Spring St.
Reed, Edsel S.....Clark Co. Memorial Hosp.
Reeder, Henry H.....Jeffersonville
Roby, Alma L.....201 E. Market St.
Shaw, Houston W.....435 Spring St.
Thompson, Walter.....1403 Youngstown Dr.
Weems, Mallory P.....404 Spring St.
Witt, William R.....Medical Center

Regan, George L.....Sellersburg
Sturgis, Donald G.....Sellersburg

CLAY COUNTY

Brazil

Garvin, Donald B.....111 N. Walnut St.
Maurer, J. Frank.....111 N. Walnut St.
Maurer, Robert M.....111 N. Walnut St.
Mehne, Richard G.....1½ E. National Ave.
Shattuck, John C.....1½ E. National Ave.
Weaver, Timothy M. (S).....Brazil Trust Bldg.
Webster, Robert K.....28 N. Franklin St.
Wood, Opal L.....111 N. Walnut St.

Moon, Charles E.....Center Point
Bond, Walter C.....Clay City
Buell, Forrest R.....Clay City
Rentschler, Lewis C. (S).....Clay City

CLINTON COUNTY

Waits, Chester L.....Colfax

Frankfort

Applegate, Albert E.....51 E. Walnut St.
Beardsley, Frank A.....51 S. Jackson St.
Carrel, Francis E.....214 Ross Bldg.
Dykhuizen, Theodore A.....59 S. Main St.
Erdel, Milton W.....2 E. White St.
Flora, Fred W.....1256 S. Jackson St.
Hammersley, George K.....361 E. Clinton St.
Hedgcock, Robert A.....259 E. Clinton St.
Stout, Harry T.....1256 S. Jackson St.
Van Kirk, Paul P.....204 W. Washington St.
Work, Bruce A.....306 Peoples Life Bldg.

Bush, Charles E.....Kirklin
Carlyle, Ivan E. (S).....Michigantown
Lind, Jaap J.....Mulberry
Grove, Robert H.....Rossville
Ketcham, John S. (S).....Rossville
Weller, Ralph D.....Rossville

Holmes, Claude D. (S)
329 Romano St., Coral Gables, Fla.
Reed, John D.....Henry Ford Hosp., Detroit, Mich.
Tedford, John H.
2325 Fernwood, Ann Arbor, Mich.

CRAWFORD COUNTY

(See Harrison-Crawford)

DAVISS-MARTIN COUNTIES

Rohrer, James R.....Elnora

Loogootee

Chattin, Robert E. 102 Wood
Lett, Emory B. 408 E. Main

Sears, Don. Odon

Washington

Arthur, Nora M. (S) R. R. 4
Blazey, Arthur G. 7 E. Walnut St.
Chattin, Vance J. 514 E. Main St.
Farris, John J. 514 E. Main St.
Fox, C. Philip 305 Peoples Bank Bldg.
Lindsay, Hamlin B. 511 E. Main St.
McKittrick, Jack Peoples Bank Bldg.
McNaughton, Lawrence M. 400 E. Hefron St.
Norton, Horace O. 511 E. Hefron St.
Rang, A. A. (S) 211 N. E. 9th St.
Rang, Robert H. 1312 Bedford Rd.
Ross, Glenn E. 1307 Bedford Road
Schafer, William C. 1312 Bedford Rd.
Schroeder, Henry R. 101 N. E. First St.
Seat, Marshall H. Williams Bldg.
Smoot, Emory B. 507 E. Main St.

DEARBORN-OHIO COUNTIES**Aurora**

Baker, Leslie M. 501 Fourth St.
Jackson, John K. 223 Mechanic St.
Olcott, Charles W. 203 Main St.
Treon, James F. (S) 505 Fifth St.

McNeely, Matthew J. Dillsboro
Elliott, John C. (S) Guilford

Lawrenceburg

Aldred, Allen W. 370 Bielby Road
Conrad, Henry 370 Bielby Road
Fagaly, William J. 238 Short St.
Frale, Frank L. 370 Bielby Road
Houston, Fred D. 30 W. High St.
Hunter, Lowell G. 370 Bielby Road
Irmscher, George W. 6 W. High St.
Morrison, George G., Jr. 209 Fourth St.
Pfeifer, James M. 319 Front St.
Streck, Francis A. 326 Walnut St.
Weisenberger, Brockton L. 370 Bielby Road

Fessler, Gordon S. Rising Sun

DECATUR COUNTY

Tremain, Milton A. (S) Adams

Greensburg

Acher, Robert P. 221 E. Washington St.
Callaghan, Winship C. 304 Bates Bldg.
Dickson, Dale D. Bates Bldg.
Miller, James C. 205 Bates Bldg.
Morrison, James T. 207 N. Franklin
Overpeck, Charles Murphy Bldg.
Shaffer, William R. 214 N. Franklin
Walker, Louis 215 N. Franklin

Harcom, Harry E. St. Paul
Porter, Edward A. Westport
Porter, Robert A. Westport

DE KALB COUNTY**Auburn**

Covell, Harry M. 127 W. Seventh St.
Geisinger, Lewis N. (S) 805 S. Indiana Ave.
Hines, Archie V. 401 S. Main St.
Hines, John H. 403 S. Main St.
Hippensteel, Harland V. 208 W. Seventh St.
Nugen, Harold 223 W. Seventh St.
Nugen, Margaret Owen 223 W. Seventh St.
Rogers, Evered E. 212 W. Sixth St.
Sanders, Jesse A. (S) 1007 S. Main St.
Souder, Bonnell M. 206 W. Seventh
Wills, Max. 127 W. Seventh St.

Weirich, Charles I. Butler

Garrett

Carpenter, Ramesh S. 514 S. Randolph
Jinnings, Loren E. 200 S. Randolph
Kantzer, Floyd B. 200 S. Randolph
Nason, Robert A. 123 E. King
Novy, Charles A. 200 S. Randolph
Reynolds, R. Perry 215 S. Randolph

Coleman, Floyd B. Waterloo
Hillsamer, Phyllis G. Waterloo
Showalter, John P. Waterloo

Van Nest, Willard A.
501 Magnolia St., New Smyrna Beach, Fla.

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D. Albany
Puterbaugh, Karl E. Albany
Hurley, John R. Daleville
Tucker, Oral A. Daleville
Ko, Richard C. B. Gaston

Hartford City

Dodds, James U. 227 W. Main St.
Dudgeon, Charles A. 720 N. Spring
Jackson, Dean B. 401 W. Washington St.
Owsley, Guy A. 214 N. High St.
Parks, George O. 720 N. Spring St.
Weldy, Bryce P. 227 W. Franklin St.
Werry, Leslie E. 218 W. Washington St.
Wierzalis, Edward F. Rural Loan Bldg.

Burns, Paul E. Montpelier

Muncie

Adams, Julia L. Ball State Teachers College
Adams, William B. Ball Memorial Hosp.
Alvey, Charles R. 217 S. Cherry St.
Ball, Clay A. (S) 303 W. Adams St.
Ball, Phillip 2620 W. Jackson St.
Batt, David J. 420 W. Washington St.
Benken, Lawrence D. 2423 W. Jackson
Bergwall, Warren L. 223 Tillotson Ave.
Bibler, Henry E. 311 W. Adams St.
Botkin, Charles (S) 508 W. Jackson St.
Botkin, Clyde G. 508 W. Jackson St.
Botkin, Thomas 400 White River Blvd.
Brown, Leland G. 412 White River Blvd.
Brown, Thomas M. 412 White River Blvd.
Burwell, Stanley W. 424 W. Jackson St.
Butterfield, Robert M. 315 W. Jackson St.
Butz, Ralph O. 1525 W. Jackson St.
Christie, Robert W. Ball Memorial Hosp.
Clevenger, Joseph H. 424 W. Jackson St.

Cochran, Robert B. 420 W. Washington St.
 Covalt, Wendell E. 2724 W. North St.
 Cooper, John. 2327 Madison St.
 Cure, Elmer T. 105 Western Reserve Bldg.
 Davis, Edgar C. (S) 203 Western Reserve Bldg.
 Deutsch, William. 406 White River Blvd.
 Dunn, Ferrell W. (S) 1417 Wheeling Ave.
 Dunning, Thomas W. 400½ White River Blvd.
 Fair, Herbert D. (S) 201 Alameda Ave.
 Funk, John W. 217 W. Charles St.
 Galliher, Marjorie J. 410 White River Blvd.
 Garling, Luvern C. 521 S. Tillotson
 Geckler, Charles E. 205 Western Reserve Bldg.
 Gibson, Robert K. 806 West Jackson St.
 Gill, Thomas A. 808 W. Jackson St.
 Greiber, Marvin F. 420 W. Washington St.
 Gustafson, Milton. 808 W. Jackson St.
 Hall, Robert S. 514 Wysor Bldg.
 Hammond, Keith E. 420 W. Washington St.
 Hayes, Theodore R. 210 S. High St.
 Henderson, Ramon A. 806 W. Jackson St.
 High, Ralph L. 420 W. Washington St.
 Hill, Howard E. 402 W. Jackson St.
 Holmes, John L. 412 White River Blvd.
 Hostetter, Irwin S. 115 N. Cherry St.
 Hurley, Anson G. 1111 W. Jackson St.
 Imhof, Joseph D. 320 W. Adams St.
 Ingram, Richard. Ball Memorial Hospital
 Kammer, Walter F. 420 W. Washington St.
 Kirshman, Forrest E. 211 S. High St.
 Koss, K. William. 1600 W. Jackson St.
 Kress, James W. 420 W. Washington St.
 McClintock, James A. 316 W. Adams St.
 McCoy, George E. 806 W. Jackson St.
 McDowell, Fletcher W. 315 S. Jefferson St.
 Mathewson, Russell C. 420 W. Washington St.
 Molloy, William J. (S) 619 E. Charles St.
 Montgomery, Lall G. Ball Memorial Hosp.
 Moore, Thomas C. 110 N. Cherry St.
 Moore, Will C. (S) 110 N. Cherry St.
 Morris, Jean W. 247 Johnson Bldg.
 Nelson, Harold E. 424 W. Jackson St.
 O'Connor, Joseph M. 420 W. Washington St.
 Owens, Thomas R. 202 Western Reserve Bldg.
 Peacock, Robert C. 2724 W. North St.
 Pippenger, Wayne G. Ball State Teachers College
 Quick, William J. 314 E. Washington St.
 Rettig, Arthur C. 314 W. Jackson St.
 Rivers, Glynn A. 625 W. Adams St.
 Schulhof, Maurice G. 420 W. Washington St.
 Smith, James S. 501 Kirby
 Speck, Carlson R. Ball Memorial Hospital
 Steele, Frank M. 420 W. Washington St.
 Stibbens, Warren. 2210 Janney St.
 Stout, Francis E. 2423 W. Jackson St.
 Taylor, Donald R. Ball Memorial Hosp.
 Taylor, James A. Delco Remy Plant
 Tomlin, Hugh M. 420 W. Washington St.
 Venis, Kemper N. 108 N. Liberty St.
 Voss, Gert 420 W. Washington St.
 Walker, Jack M. 412 White River Blvd.
 Ware, Herbert E. 314 W. Jackson St.
 Young, Gerald S. 316 W. Jackson St.

Jump, Charles A. (S) Selma
 Hill, Robert E. Yorktown
 Moss, Mavor J. Yorktown

DUBOIS COUNTY

Backer, Henry G. Ferdinand

Huntingburg

Amini, Sohrab. 521 Fourth St.
 Bretz, John M. 302 Fourth St.
 Heaton, Elton 409 Van Buren
 Scales, Alfred B. 407 Van Buren

Scales, Allen D. 409 Van Buren
 Steinkamp, Emil F. (S) 302 Walnut St.
 Stork, Harvey K. 530 Fourth St.
 Williams, Fielding P. 215 W. Walnut St.

Jasper

Beaven, John B. 111 Central Bldg.
 Blessinger, Paul J. 325 E. Sixth St.
 Gootee, Francis H. 501 Clay St.
 Gootee, Thomas H. 501 Clay St.
 Heck, Martin C. 801 Newton
 Held, George A. 715 McArthur
 Klamer, Charles H. Metzger Bldg.
 Lukemeyer, St. John. 109 W. 12th St.
 Ploetner, Edward J. 201 W. Sixth St.
 Salb, John P. 106 Metzger Bldg.
 Salb, Leo A. (S) 301 E. Sixth St.
 Singer, Paul J. 116 E. Seventh St.
 Wagner, Arthur L. 115 E. Ninth St.

ELKHART COUNTY

Horswell, Richard G. Bristol
 Neidballa, Edward G. Bristol

Elkhart

Arlook, Theodore D. 912 W. Franklin St.
 Atwood, William H. 405 S. Second St.
 Bender, Robert L. 411 S. Third St.
 Benson, James E. 405 S. Second St.
 Billings, Elmer R. 405 S. Third St.
 Bloom, George R. 506 S. Second St.
 Boling, Richard. 214 W. Marion St.
 Bowdoin, George E. 515 S. Second St.
 Campbell, Patrick B. 605 Oakland Ave.
 Classen, Pete R. C. 4112 S. Main St.
 Compton, Walter A. 2225 Greenleaf Blvd.
 Cormican, Herbert L. 413 W. Franklin St.
 Crandall, Lathan A.

Miles-Ames Research Laboratory

Dovey, Edward G. 513 Oakland Ave.
 Echeverria, Rodolfo E. 405 S. Second St.
 Elliott, Thomas A. 405 S. Second St.
 Finfrock, James D. 811 Laurel St.
 Fleming, Claude F. (S) 217 W. Jefferson St.
 Futterknecht, James O. 405 S. Second St.
 Ganser, Ralph V. 405 S. Second St.
 Gattman, George B. 427 S. Second St.
 Graber, Virgil R. 413 W. Franklin St.
 Gray, Mary Case. 518 W. Franklin St.
 Hannah, Jack W. 1906 E. Jackson Blvd.
 Harris, Neil. 307 S. Seventh St.
 Heminway, Norman L. Miles-Ames Research Labs.
 Hurley, James W. 405 S. Second St.
 Ivy, John H. 405 S. Second St.
 Keating, John U. 215½ W. Lexington
 Kesim, Mufti. 603 Oakland
 Kintner, Burton E. 506 S. Second St.
 Kistner, Arthur W. 400 Equity Bldg.
 Koehler, Elmer G. 416 W. Lexington Ave.
 Krause, Friedrich. 4112 S. Main St.
 Lundt, Milo O. 521 S. Second St.
 McArt, Bruce A. 123 W. Marion St.
 Martin, Paul H. 313 N. Second St.
 Mendez, Carlos. 116 W. Marion St.
 Middleton, Ramona J. 209 S. Second St.
 Miller, Galen R. 903 W. Franklin St.
 Miller, Hugh A. 819 McNaughton Ave.
 Miller, Samuel T. (S) 506 S. Second St.
 Mininger, Edward P. 413 W. Franklin St.
 Mishkin, Irving. 209 S. Second St.
 Norris, Allen A. (S) 401 W. Marion St.
 Paff, William A. 115 S. Third St.
 Paine, George E. 329 Meisner Ave.
 Pancost, Vernon K. 1000 W. Marion St.
 Parshall, Dale B. 133 W. Lusher Ave.
 Patrick, Glenn B. 427 S. Second St.
 Rouen, Robert. 114 Monger Bldg.
 Rupe, Lloyd O. 209 Equity Bldg.

Schlosser, Herbert C. 116 W. Marion St.
 Sears, Murray M. (S) 304 Equity Bldg.
 Sobol, Z. W. 405 S. Second St.
 Spray, Page E. 316 S. Fourth St.
 Stauffer, Walter A. (S) 701 Strong Ave.
 Stubbins, William M. 412 S. Second St.
 Swank, Lucretia 1600 E. Jackson Blvd.
 Swihart, Danny D. 506 S. Second St.
 Swihart, Homer R. 1200 W. Marion St.
 Wilson, Orley E. 217 N. Main St.
 Work, James A., Jr. (S) 406 S. Second St.
 Yoder, C. Richard 603 Oakland
 Zeitler, Philip S. 513 Oakland

Goshen

Amstutz, Henry C. 112 W. High Park
 Bartholomew, Mary L. 317 E. Lincoln
 Bigler, Frederick W. 314 S. Fifth St.
 Bosler, Howard A. 214 Waterford Road
 Bowser, Philip G. 107 S. Fifth St.
 Chandler, Leon H. 43 Shoots Bldg.
 Hostetler, Carl M. 304 E. Lincoln
 Kaufman, Lillie S. 901 Mervin Ave.
 Kennedy, Myron S. 314 S. Fifth St.
 Krabill, Willard S. 112 W. High St.
 Martin, Floyd S. 127 E. Lincoln
 Quilty, Thomas J. 112 E. Madison St.
 Simmons, Lloyd H. 203 E. Lincoln
 Troyer, Dana. 122 E. Clinton St.
 Troyer, George W. 314 E. Lincoln Ave.
 Turner, John P. 115 E. Washington St.
 Wagner, David G. 307 S. Seventh St.
 Westfall, George S. 214 E. Lincoln St.
 Yoder, Albert C. (S) 816 S. Sixth St.
 Young, Ralph H. 113 E. Madison

Massanari, Walter Millersburg
 Miller, Donald G. Middlebury
 Teters, Melvin S. Middlebury

Nappanee

Fleetwood, Raymond A. 357 N. Nappanee
 Kendall, Forest M. 252 W. Market St.
 Price, Douglas W. 162 E. Market St.
 Roose, Lisle W. 357 N. Nappanee
 Slabaugh, Jancy S. (S) 111 N. Main St.

De Fries, John J. New Paris
 Guttman, John B. Wakarusa

Todd, David D. (S)
 5835 Beaumont Ave., La Jolla, Calif.

FAYETTE-FRANKLIN COUNTIES**Brookville**

Foreman, Walter A. 617 Main St.
 Peters, Elmer E. 830 Main St.
 Seal, Perry F. 901 N. Main St.
 Smith, Herbert N. 812 Main St.

Connersville

Dale, Maxwell H. 818 Grand
 Ellis, George M. 108 E. 10th St.
 Gregg, Albert F. 124 E. Sixth St.
 Hudson, Arlington M. 321 W. 20th
 Kemp, William A. 122 W. Seventh St.
 Kerrigan, William F. 718 Central Ave.
 Lockhart, Jack M. 707 W. Third St.
 Mountain, Francis B. 930 Central Ave.
 Neukamp, Frank H. 707 W. Third St.
 Sanders, Bertram W. 930 Central Ave.

Steinem, Joseph L. 812 Grand Ave.
 Watterson, Gerald T. 1910 Virginia Ave.
 Winklepleck, A. M. R. R. #6

Poston, Clement L. R. R. 2, Laurel

FLOYD COUNTY

Engleman, Harry K. (S) Georgetown

New Albany

Baker, Avey M. 811 E. Spring St.
 Baxter, Samuel M. 1201 E. Spring St.
 Brown, Kenneth H. 410 E. Spring St.
 Buchman, Marshall H. 1824 State St.
 Byrn, Howard W. (S) 415 Elsby Bldg.
 Cannon, Daniel H. 1203 E. Spring St.
 Davis, Parvin M. 601 E. Spring St.
 Eckerle, John E. 313 W. Daisy Lane
 Edwards, William F. 356 Vincennes St.
 Garner, William H., Jr. 919 E. Spring St.
 Garner, William H., Sr. 919 E. Spring St.
 Gentile, John P. 101 Adams St.
 Geyer, Joseph H. Silvercrest Sanitarium
 Harris, Robert W. 2652 Charlestown Rd.
 Hauss, Augustus P. (S) 212 Elsby Bldg.
 Hess, Paul P. Floyd Co. Bank Bldg.
 Higgins, John R. 700 E. Spring St.
 LaFollette, Donald 1000 E. Spring St.
 LaFollette, Robert E. 1000 E. Spring St.
 McCullough, James Y. 700 E. Spring St.
 May, William D. Silvercrest Sanitarium
 Nedelkoff, Bogdan 1809 Woodland Road
 Paris, John M. 602 E. Spring St.
 Pierce, Gene S. 1696 Garretson Lane
 Robertson, Addis N. 820 E. Spring St.
 Robinson, Nan 601 E. Spring St.
 Shelton, Clyde F. 601 E. Spring St.
 Sloan, Herbert P. 1207 E. Spring St.
 Sonne, Irvin S., Jr. 1850 State St.
 Streepey, Jefferson I. 1102 E. Spring St.
 Tyler, Frank T. (S) Hausfeldt Lane
 Voyles, Harry E. 213 Elsby Bldg.
 Wallace, Elmer L. 1516 State St.
 Weaver, William W. 1104 E. Spring St.
 Wolfe, Nelson 1117 E. Spring St.
 Worley, Henry L. 1104 E. Spring St.

FOUNTAIN-WARREN COUNTIES**Attica**

Fisher, John E. 217 S. Perry St.
 Maris, Lee J. 201 Brady
 Petrich, Peter R. 401 S. Perry St.
 Raymundo, Vivencio F. 401 S. Perry St.

Hoffman, Max N. Covington
 Humphrey, Edward M.

Olin Mathieson Corp., Covington
 Stephens, Lowell R. Covington
 Suzuki, Tsutomu T. Covington
 Furr, Jack D. Kingman
 Smith, Byron J. Kingman
 McCord, Carl B. (S) Veedersburg
 Person, Theodore C. Veedersburg
 Rusk, Hubert M. Wallace
 Nelson, Carl A. West Lebanon
 Crain, James W. Williamsport

FULTON COUNTY

Herrick, Charles L. Akron
 Miller, Virgil C. Akron
 Dielman, Franklin C. (S) Fulton

Kelsey, Lawrence E.....Kewanna
Kraning, Kenneth K.....Kewanna

Rochester

Herendeen, Elbie V.....120 W. Ninth St.
Richardson, Charles L.....121 W. Eighth St.
Rowe, Howard H.....705 Jefferson St.
Stinson, Dean K.....816 Main St.

GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Marchand, Edwin V.....Haubstadt
Petitjean, Harold G.....Haubstadt
Dye, William E.....Oakland City
Ropp, Eldon R.....Oakland City

Princeton

Carpentier, Harry F.....105 E. Broadway
Folck, John K.....115 N. Prince St.
Graves, Orville M.....116 S. Hart St.
McCarty, Virgil.....113 S. Main St.
McElroy, Robert S.....116 S. Main St.
Peck, James F.....218 Broadway
Strickland, Karl S. (S).....230 W. Broadway
Weitzel, Roland E.....114 S. Hart St.
Wells, William R.....109 E. State St.

Brazelton, O. T. (S)
5450 55th St., No. 14, San Diego 15, Calif.

GRANT COUNTY

Grant, M. Arthur.....Fairmount
Henley, Glenn (S).....Fairmount
Yale, Charles A.....Fairmount
Garrison, Leon J.....Gas City
Koontz, William A.....Gas City
Shoemaker, Richard L.....Gas City
Baskett, Russell J.....Jonesboro

Marion

Abell, Charles F.....500 Wabash Ave.
Alderfer, Henry.....131 N. Washington St.
Ansbacher, Stefan (H).....Fox Station Rd. W.
Ayres, Wendell W.....500 Wabash Ave.
Bailey, Douglas A.....107 E. 31st St.
Bloom, Asa W.....724 W. Third St.
Boyer, Grace B.....605 Locust St.
Braunlin, Robert F.....711 Marion Nat'l Bank Bldg.
Brown, Robert M.....520 Marion Nat'l Bank Bldg.
Comeau, William J.....Marion General Hosp.
Cunningham, Robert D.....500 Wabash Ave.
Daniels, George R. (S).....106 N. E Street
Davis, Joseph B.....131 N. Washington St.
Davis, Merrill S. (S).....131 N. Washington St.
Davis, Richard M.....131 N. Washington St.
Dunbar, Fred E.....Fisher Body Division
General Motors Corp.
Fisher, Henry.....1502 S. Washington St.
Ganz, Max.....930 S. Adams
Goldsmith, David A.....Veterans Hospital
Gustafson, Carl J.....Veterans Hospital
Hover, Galen M.....Veterans Hospital
Hummel, Russel M.....500 Wabash Ave.
Jarrett, John C.....131 N. Washington St.
Lahr, Richard E.....1121 W. Third St.
Langrall, Harrison M., Jr.....131 N. Washington St.
Larson, George E.....410 Marion Nat'l Bank Bldg.
Lavengood, Russell W.....225 Glass Block
Long, Max R.....803 S. Boots St.
Lonngren, Dudley H.....131 N. Washington St.
Love, V. Logan.....131 N. Washington St.

Miller, H. Allison.....320 Glass Block
Oatman, Jack G.....131 N. Washington St.
Pattison, John D.....131 N. Washington St.
Pearcy, Marcene.....500 Wabash Ave.
Powell, J. Paxton.....500 Wabash Ave.
Price, Ambrose M.....219 E. 30th St.
Reid, James D.....505 Buckingham Dr.
Renbarger, Lester L.....1531 W. Second
Rhamy, Arthur P.....500 Wabash Ave.
Rhamy, Donald E.....1632 Broadview Dr.
Rhorer, John G.....500 Wabash Ave.
Richardson, Joseph H.....131 N. Washington St.
Roll, William A.....131 N. Washington St.
Schroeder, Robert W.....317 N. Western Ave.
Simmons, Frederick H.....1009 N. Baldwin
Skomp, Claud E.....500 Wabash Ave.
Smith, Barton T.....131 N. Washington St.
Snowwhite, Arthur B.....500 Wabash Ave.
Thompson, B. Jay.....Marion General Hosp.
Walton, R. Lee.....131 N. Washington St.
Warren, Carroll B.....511 Glass Block
Weinberg, Samuel.....104 W. Third St.
Wojcik, Ladislav D.....131 N. Washington St.
Woodbury, John W.....131 N. Washington St.
Young, Robert G.....2927 S. Washington St.

Beck, Thomas A.....Swayzee
Taylor, Everett C.....Upland
Rifner, Eugene S.....Van Buren

GREENE COUNTY**Bloomfield**

Graf, Jerome A.....6 E. Main St.
Mount, Mathias S.....55 N. Franklin St.
Turner, Harold B. (S).....126 E. Indiana Ave.
Turner, Jack J.....126 E. Indiana Ave.
Van Sandt, Frank A. (S).....110½ E. Main St.

Porter, Carl M.....Jasonville
Rotman, Harry G.....Jasonville
Rotman, Sam I.....Jasonville

Linton

Bailey, Edwin B.....129 E. Vincennes
Broshears, Kenneth P.....129 E. Vincennes
Raney, Ben B.....129 E. Vincennes
Tomak, Milton E.....289 N. Main St.
Woner, John W.....Linton

Hamilton, M. Luther (S).....Newberry
Moses, George E.....Worthington
Moses, Robert E.....Worthington

HAMILTON COUNTY

Karlick, Joseph.....Arcadia
McDaniel, Franklin P. (S).....Atlanta
Donahue, Claude M.....Carmel
Hasewinkel, Carroll W.....R. R. 2, Box 354, Carmel
Thomas, W. Clayton.....Carmel
Havens, Oscar.....Cicero

Noblesville

Ambrose, Jesse C.....298 N. Ninth Street
Campbell, Sam W.....88 S. 19th St.
Carter, Robert E., Jr.....1084 Clinton St.
Harris, Robert F.....120 N. 9th St.
Hash, John S.....139 S. 10th St.
Haywood, John G.....120 N. 11th St.
Hooke, Samuel W. (S).....P. O. Box 224
Kraft, Haldon C.....195 S. 10th St.
Kern, Charles B. (S).....10 Heather Lane, R. R. 3

Lanning, R. Adrian.....10th and North Dr.
 Lloyd, Joe R.....148 N. 9th St.
 Shanks, Ray W.....104 S. 10th St.
 Smith, Charles F.....23 N. 10th St.
 Southard, Carl B.....55 S. 16th St.

Griffith, James W.....Sheridan
 Newby, Eugene.....Sheridan
 Reck, John L. (S).....Sheridan
 Waitt, Paul M.....Sheridan
 Connoy, Andrew F.....Westfield
 Connoy, Leo F.....Westfield

HANCOCK COUNTY

Scott, Robert S.....Charlottesville
 Ferrell, Mars B.....Fortville
 Navin, Hugh K.....Fortville
 Rhynearson, Hal R.....Fortville

Greenfield

Beeson, Wilbur P.....114 N. State St.
 Endicott, Wayne H.....10 W. Boyd
 Farrell, John J., Jr.....1001 N. State St.
 Gibbs, Charles M. (S).....203 E. North St.
 Gill, Dee D.....1001 N. State St.
 Henn, R. Anthony.....211 W. Main St.
 Hunter, Donn R.....10 W. Boyd
 Kinneman, Robert E.....114 N. State St.
 Kirby, Ted C.....114 N. State St.
 Smith, John H.....744 N. State St.
 Vings, Bronie.....746 N. State
 Woods, James R., Jr.....11 N. State St.

Cagle, Bob R.....New Palestine
 Pierson, Thomas A.....New Palestine
 Kuhn, Robert W.....Wilkinson

HARRISON-CRAWFORD COUNTIES

Corydon

Amy, William E. (S).....120 S. Capitol
 Blessinger, Louis H.....101 W. Chestnut St.
 Brockman, Wilfred.....439 E. Chestnut St.
 Dillman, Carl E.....Beaver & Oak Sts.
 Dukes, David J.....439 E. Chestnut St.
 Jordan, Richard A.....Harrison Dr.
 Martin, Samuel W.....R.R. 1

Baker, Guy D (S).....Crandall
 Gobbel, Novy E. (S).....English
 Seipel, Stanley.....Lanesville
 Benz, Jesse (S).....Marengo
 Lynch, Otis R.....Marengo
 Mathys, Alfred (S).....Mauckport
 Johnson, Jerome M.....Palmyra

HENDRICKS COUNTY

Black, M. James.....702 E. Main St., Brownsburg
 Foltz, Lloyd E.....20 W. Main, Brownsburg
 Scudder, Arthur N.....24 N. Grant St., Brownsburg
 Ellett, John, Jr.....Coatesville

Danville

Kirtley, Robert W.....138 W. Marion St.
 Koch, Elmer L.....201 E. Columbia St.

Southard, James E.....985 W. Main St.
 Terry, Lloyd.....138 W. Marion St.

Ellis, Lyman H.....Lizton
 Wiseheart, Oscar H. (S).....North Salem
 Scamahorn, Malcolm O.....Pittsboro
 Scamahorn, Oscar T. (S).....Pittsboro

Plainfield

Aiken, Milo M.....140 N. Center St.
 Cohen, Irving.....645 E. Main St.
 Haggard, David B.....P. O. Box 191
 Stafford, William C.....107 W. Main St.
 Warbinton, Fred P.....P. O. Box 191

Frantz, Mount E.

3530th USAF Hosp., Bryan AFB, Texas

HENRY COUNTY

Call, Earle B. (S).....Knightstown
 Smith, Stephen D.....Knightstown
 Wiatt, Leonard H.....Knightstown
 Schetz, Marion R.....Lewisville
 Hammer, Jay W.....Middletown
 Reynolds, Ralph E.....Middletown
 Stauffer, George E.....Mooreland
 Marshall, Lloyd C. (S).....Mt. Summit

New Castle

Amos, Robert L.....1219 1/2 Race St.
 Balcolm, Francis H.....2003 Wuthering Dr.
 Bledsoe, James G.....319 S. 14th St.
 Brock, Joseph T.....New Castle State Hosp.
 Burnett, Arthur B.....106 N. Main St.
 Cain, David R.....New Castle State Hosp.
 Craig, Alexander F.....415 Raintree Dr.
 Davies, Robert.....1319 Church St.
 Dyken, Mark L.....New Castle State Hosp.
 Fisher, John E.....540 S. Main St.
 Foster, Ray T.....420 N. Main St.
 Grant, Phyllis A.....New Castle State Hosp.
 Harrison, Benjamin L.....540 S. Main St.
 Heilman, William C. (S).....1319 Church St.
 Heilman, William C., Jr.....1319 Church St.
 Hill, Kenneth G.....1319 Church St.
 Itermann, George E. (S).....1319 Church St.
 Kennedy, Walter U. (S).....208 Union Block
 Life, Homer L.....1015 Broad St.
 Lowery, George E.....New Castle State Hosp.
 McDonald, Frank C.....527 S. Main St.
 McElroy, James S.....1319 Church St.
 McGee, Robert R.....527 S. Main St.
 McKee, Roy G.....319 S. 14th St.
 Murray, William E.....New Castle State Hosp.
 Saint, William K.....540 "B" South Main St.
 Smith, Mark E.....1319 Church St.
 Steussy, Calvin, N.....Henry Co. Hospital
 Stout, Walter M. (S).....1319 Church St.
 Stricker, Paul J.....319 S. 14th St.
 Thorne, Charles E.....200 N. 12th St.
 Tully, John A. (S).....502 S. Main St.
 Vivian, Donald E.....Henry County Hospital
 Wiggins, Dulanía S. (S).....219 S. 12th St.

Robertson, William S.....Spiceland
 Marsh, Chester A. (S)
 906 Dexter St., Los Angeles 42, Calif.

HOWARD COUNTY

Denton, Larkin D.....Greentown
 Shoup, Homer B.....Greentown

Kokomo

Alward, John H. 321 W. Walnut St.
 Artis, Myrle E. 107½ S. Union St.
 Ault, Carl H. 502 S. Berkley Rd.
 Behn, Walter M., Jr. 700 E. Firmin
 Belding, Ray T. 3130 S. La Fountain St.
 Boughman, Joe D. 2008 W. Sycamore
 Bowers, Copeland C. 210 W. Mulberry St.
 Bowers, Garvey B. 210 W. Mulberry St.
 Bowers, John A. 210 W. Mulberry St.
 Brown, Earl R., Jr. 1907 W. Sycamore St.
 Bruegge, Theodore J. 2108 W. Sycamore
 Cattell, Lee M. 214 E. Mulberry St.
 Clarke, Elton R. 1039 S. Main St.
 Conley, Thomas M. 500 Southway Blvd. East
 Craig, Reuben A. 514 W. Superior St.
 Craig, Reuben. 514 W. Superior St.
 Crawford, Theodore R. 2114 W. Sycamore St.
 Earl, Max M. 502 S. Berkley Rd.
 Ferry, Paul W. 406 Union Bank Bldg.
 Fields, Donald L. 500 Southway Blvd. East
 Frazier, John L. 500 Southway Blvd. East
 Fretz, Richard C. 215 W. Superior St.
 Golper, Marvin N. 1907 W. Sycamore St.
 Good, Richard P. 400 S. Berkley Rd.
 Grothouse, Carl B. 402 S. Berkley Rd.
 Halfast, Richard W. 402 S. Berkley Rd.
 Hoyt, John M. 416 W. Sycamore St.
 Hutto, William H. 215 W. Superior St.
 Jewell, George M. 610 Armstrong-Landon Bldg.
 Kremers, George A. 404 S. Berkley Rd.
 McClure, Warren N. 407 W. Taylor St.
 McIndoo, Ralph E. (S) 313 W. Taylor St.
 Mendelson, Stanley M. 117 W. Markland
 Michael, Robert L. 321 W. Walnut St.
 Morrison, William R. 504 Union Bank Bldg.
 Murray, Ernest C. 501 N. Washington St.
 Paris, Durward W. 614 Armstrong-Landon Bldg.
 Perkins, Powell L. 2112 W. Sycamore
 Phares, Robert W. 905 W. Mulberry St.
 Prather, Philip E. 909 S. Courtland
 Ramey, John W. 107½ S. Union St.
 Rhorer, Herbert M. 415½ W. Sycamore St.
 Rudicel, Max. 1907 W. Sycamore St.
 Schwartz, Frederick C. 2016 W. Sycamore
 Shenk, Earl M. (S) 208½ N. Main St.
 Smith, Gloster J. 102½ S. Main St.
 Sorenson, Raymond. 404 S. Berkley Rd.
 Spangler, Jesse S. 215 E. Taylor St.
 Trimble, John G. 116 S. Buckeye St.
 Wachob, Tom W., Jr. 406 Armstrong-Landon Bldg.

Wible, James H. 2112 W. Sycamore St.

Miller, Arthur H. (S) Russiaville
 Ware, John R. Russiaville

HUNTINGTON COUNTY**Huntington**

Brubaker, Harold S. 42 W. Park Dr.
 Casey, Stanley M. 408 E. Market St.
 Clark, Joseph. 818 W. Park Dr.
 Clunie, William A. 323 W. Park Dr.
 Cope, Stanton E. 1022 N. Jefferson St.
 Erehart, Mark G. Maple Grove Rd., R. R. 8
 Eviston, John B. 34 E. Washington St.
 Grayston, Wallace S. (S) 303 E. Market St.
 James, Thomas, Jr. 202 U. B. Publishing Bldg.
 Johnston, Robert G. (S) 339 E. Market St.
 Marks, Howard H. 248 W. Park Dr.
 Meiser, Robert D. 612 N. Jefferson St.
 Mitman, Floyd B. 210 W. Park Dr.
 Nie, Grover M. (S) 1518 Cherry St.
 Omstead, Trevalyn W. 229 Vine St.
 Wagner, Richard. 1355 Guilford

Woods, Halden C. Markle

Cooper, B. Trent. Roanoke
 Bennett, J. B. Warren
 McIlwain, Eleanor E. Methodist Home, Warren
 McIlwain, Robert E. Methodist Home, Warren
 Ray, Carl S. Warren
 Miller, Wayne S. 1926 Park Forest Dr., Flint, Mich.

JACKSON COUNTY

Gillespie, Garland R. Brownstown
 Shields, Jack E. Brownstown
 Adair, William K. (S) Crothersville
 Bard, Frank B. Crothersville
 Butler, Joe B. Crothersville
 Scharbrough, William. Ewing

Seymour

Baxter, Harry R. 326 N. Walnut St.
 Black, Joe M. 502 W. Second St.
 Bobb, Kenneth E. 406 S. Chestnut St.
 Bosch, Ralph. 635 W. Second St.
 Graessle, Harold P. 304 W. Second St.
 Martin, Guy. 105 N. Walnut St.
 Miller, Harold E. Vehslage Bldg.
 Osterman, Louis H. 315 W. Second St.
 Ripley, John W. 321 Bruce St.
 Templeton, Ian S. 207 N. Pine St.
 Wiethoff, Clifford A. 214 N. Walnut St.

JASPER-NEWTON COUNTIES

Schoonveld, Arthur Brook
 Parker, John C. Goodland
 Kresler, Leon E. Kentland
 Yegerlehner, Roscoe S. Kentland
 Brady, Kingdon. Morocco
 Schantz, Richard. Remington

Rensselaer

Beaver, Ernest R. 111 Thompson St.
 Greene, Robert W. 212 S. Van Rensselaer St.
 Cripe, Edwin F. Jasper County Hosp.
 O'Brien, Francis E. McKinley and Washington Sts.
 Ockerman, Kenneth R. 119 W. Harrison St.
 Williams, Paul A. 119 W. Harrison St.

Gwin, Merle D. (S) 2111 Regatta Ave., Miami Beach, Fla.

JAY COUNTY**Dunkirk**

Entner, Charles L. 125 E. Commerce
 Heller, Nelson L. R. (S) 354 E. Washington St.
 Shroyer, Herbert. 244½ S. Main St.
 Tate, Elizabeth. 317 S. Main St.

Portland

Badders, Ara C. (S) 226 W. Main St.
 Cring, George V. (S) 210 W. Walnut St.
 Cripe, William. 302 N. Meridian St.
 Cronin, H. Joseph. Weiler Bldg.
 Fitzpatrick, James S. 603 W. Arch St.
 Gillum, Eugene M. 522 W. Arch St.
 Keeling, Forrest E. 504 W. Arch St.
 Lyon, Florence M. 127 E. North St.
 Moran, Mark M. (S) 105 S. Commerce
 Morrison, George C. Weiler Bldg.
 Schenck, Ralph E. 603 W. Arch St.
 Spahr, Donald E. 615 W. Race St.
 Steffy, Ralph M. 504 W. Arch St.

JEFFERSON-SWITZERLAND COUNTIES**Madison**

Alcorn, Merritt O. R. R. 2
 Childs, Wallace E. 412 E. Main St.
 Chun, Wallace H. 2249 Crescent St.
 Davis, Lloyd H. (S) Madison State Hospital
 Fong, Theodore C. C. Madison State Hospital
 Gambill, J. Randolph Madison State Hospital
 Haney, William 445 Clifty Dr.
 Hare, Francis W., Jr. 722 W. Main St.
 Jolly, Lewis E. 722 W. Main St.
 Karnafel, Eugene T. Madison State Hospital
 May, George A. 426 E. Main St.
 McAtee, Ott B. Madison State Hospital
 Modisett, Jackson W. 722 W. Main St.
 Modisett, Marcella S. 722 W. Main St.
 Moore, Martha Madison State Hospital
 Pratt, Ralph M., Jr. 323 Poplar St.
 Prenatt, Francis Madison State Hospital
 Rucker, Warren R. 426 E. Main St.
 Shuck, William A. Odd Fellows Bldg.
 Sloan, W. Keith 426 E. Main St.
 Turner, Anna Goss. 104 E. Third St.
 Turner, Oscar A. (S) 602 E. Second St.
 Zink, Robert O. 722 W. Main St.

Graves, Noel S. Vevay
 Hamilton, Antha A. Vevay

JENNINGS COUNTY

Easter, James N. Muscatatuck State School,
 Butlerville
 Guthrie, William H.
 Muscatatuck State School, Butlerville
 Hingeley, John E.
 Muscatatuck State School, Butlerville
 Hopkins, Lester H.
 Muscatatuck State School, Butlerville

North Vernon

Berkshire, Shaffer B. 245 Norris Ave.
 Calli, Louis. 403 S. State St.
 Ellis, F. D. Long St.
 Johnson, William A. 245 Norris Ave.
 Matthews, Dennis W. (S) 109 E. Walnut St.
 Thayer, Benet W. 20 S. Jackson St.

JOHNSON COUNTY

Earnhart, Harold H. Shelbyville Rd., Edinburg
 Elleman, John H. Shelbyville Rd., Edinburg
 Lutes, David L. (S) 305 S. Kyle St., Edinburg

Franklin

Andrews, Hugh K. 176 E. Jefferson St.
 Bullers, Robert C. 551 Center St.
 Bullington, George E. 251 E. Jefferson St.
 Chappel, Alfred T. 100 N. Main St.
 Deppe, Charles F. 301 E. Jefferson St.
 Ferrara, Joseph F. 1107 N. Main St.
 Foster, Robert. 301 E. Jefferson St.
 Hibbs, William G. Masonic Hospital
 Jones, Charles A. 251 E. Jefferson St.
 Mock, Harry E., Jr. 901 N. Main St.
 Portteus, Walter L. 1551 N. Main St.
 Province, Oran A. 100 N. Main St.
 Province, William D. 100 N. Main St.
 Records, Arthur W. 198 E. Jefferson St.
 Ritteman, George W. Johnson Co. Memorial Hosp.
 Stogsdill, Willis W. 176 E. Jefferson St.
 Walters, Jack. 1551 N. Main St.
 Waymire, William. 1551 N. Main St.

Greenwood

Barnes, Helen Beall. 360 S. Madison Ave.
 Brown, George E. 374 S. Madison Ave.
 Chambers, Pauline D. 360 S. Madison Ave.
 Fox, Richard. 360 S. Madison Ave.
 Kunz, Albert L. 510 Howard Rd.
 Onyett, Harold R. Smith Valley Rd.
 Sheek, Kenneth I. 188 Madison Ave.
 Snodgrass, Robert E. 360 S. Madison Ave.
 Tiley, George A. 41 N. Madison Ave.
 Young, Joseph. 108-A Professional Bldg.

Machledt, John H. Whiteland

KNOX COUNTY**Bicknell**

Byrne, Robert J. 207 N. Main St.
 Meade, Walter W. 403 N. Main St.
 Shanklin, Jack L. 417 N. Main St.
 Wilson, Guy H. 120 W. Third St.

Springstun, George H. Oaktown

Vincennes

Anderson, John B. 301 LaPlante Bldg.
 Anderson, Richard M. 301 LaPlante Bldg.
 Arbogast, Paul B. 915 Main St.
 Barrett, Thomas L. 1019 Dubois St.
 Bartlett, Donald T. 1045 Washington Ave.
 Beckes, Ellsworth W. 220 N. Fifth St.
 Black, Boyd K. Good Samaritan Hospital
 Cantwell, Edgar R. 302 Busseron St.
 Chattin, Herbert O. 729 Main St.
 Coffel, Melvin H. 424 LaPlante Bldg.
 Corsentino, Bart E. Good Samaritan Hospital
 Curtner, Myron L. (S) 222 N. Sixth St.
 Edwards, Edward T., Jr. 34 S. Seventh St.
 Ewing, Nathaniel D. 14 N. Third St.
 Green, Carl L. 1004 Main St.
 Hendrix, Charles E. 603 Busseron
 Hoffman, Doris. 720 Perry St.
 Humphreys, Joe E. 1516 N. Second St.
 Jones, John G. (S) 210 N. Third St.
 Kline, Charles D. 301 American Bank Bldg.
 McCormick, Hubert D. (S) 325 LaPlante Bldg.
 McDowell, Mordecai M. 611 Dubois St.
 McMahan, Virgil C. 609 Dubois St.
 Moore, Robert G. 21 N. Third St.
 Nichols, Robert J. 605 Busseron St.
 Reilly, James F. 401 Buntin St.
 Richards, David H. (S) 1529 Old Orchard
 Schulze, William. 310 Buntin St.
 Shaffer, Kenneth L. 404 LaPlante Bldg.
 Smith, Ralph O. 603 Busseron
 Smith, S. Joseph. 301 LaPlante Bldg.
 Spencer, Frederic. 429 S. Sixth St.
 Stein, Richard H. 301 American Bank Bldg.
 Stewart, J. Frank W. Hillcrest Hospital
 Sullenger, Adron A. 605 Busseron
 Vaughn, Walter R. 615 Dubois St.
 von der Lieth, William C. 14 N. Third St.
 Welch, Norbert M. 615 Dubois St.

KOSCIUSKO COUNTY

Urschel, Dan L. Mentone
 Wilson, Wymond B. Mentone
 Hursey, Virgil G. Milford
 Rheinheimer, Floyd L. Milford
 Stalter, Gaylord W. North Webster
 Mishler, Joseph B. Pierceton
 Yoder, Dewey D. R. R. 1, Pierceton

Pierson, Pearl H. Silver Lake
 Clark, Jack P. Syracuse
 Craig, Robert A. Syracuse
 Fosbrink, Ephraim L. Syracuse
 Zimmerman, William H. R. R. #2, Syracuse

Warsaw

Arford, John E. 102 E. Fort Wayne
 Baum, John R. 212 S. Indiana
 Cron, William J. 215 S. High St.
 Dormire, Robert D. 600 E. Winona Ave.
 DuBois, Charles C. (S) 800 E. Center St.
 Hashemi, Hossein. 215 S. High St.
 Hammond, George. Ted Williams Dr., R. R. 2
 Hillery, John. 208 E. Center St.
 Johnston, Richard M. 202 Argonne
 Richer, Orville H. 914 E. Main St.
 Schlemmer, George H. Murphy Medical Center
 Shrader, Carl E. 600 E. Winona Ave.
 Thomas, Everett W. 212 S. Indiana

Johnson, John J. 316 W. Third St., Dixon, Ill.

LAGRANGE COUNTY

Wade, Alfred A. (S) Howe
 Yunker, Philip E. Howe

LaGrange

Benedict, Charles D. 203 W. Wayne St.
 Flannigan, Harley F. 213 W. Lafayette
 Miller, Jerry A. Medical Bldg.
 Studebaker, Lloyd R. Medical Bldg.

Williams, John H. Shipshewana
 Lehman, Kenneth M. Topeka
 Weir, Dale. 3030 Beals Branch Rd., Louisville, Ky.

LAKE COUNTY

Heckaman, Edward L. R. R. 1, Box 4, Cedar Lake
 King, Robert W. R. R. 1, Box 6, Cedar Lake
 Miller, Donald C. R. R. 2, Box 337, Cedar Lake
 Misch, William. R. R. 2, Box 337, Cedar Lake

Crown Point

Becker, Philip H. Lake County Tuberculosis San.
 Bernoske, Daniel G. Court House
 Birdzell, John P. 124 N. Main St.
 Carroll, Mary E. 124 N. Main St.
 Dhein, Donald T. 47 W. 68th Place
 Doherty, Raymond J. 47 W. 68th Place
 DuSold, Donald D. 306 E. Joliet
 Gray, Daniel E. 182 W. North St.
 Gutierrez, Peter E. 123 N. Court St.
 Horst, William N. 123 N. Court St.
 Monroe, F. Bruce. 40 West 73rd St.
 Russo, Andrew E. 224 S. Court St.
 Steele, Everett B. 109 E. North St.
 Troutwine, William R. 224 S. Court

Theobald, Sterling. 212 Joliet St., Dyer

East Chicago

Bacevich, Andrew J. 3406 Guthrie St.
 Balingit, Benjamin L. Inland Steel Co.
 Barron, Elmer A. 3406 Guthrie St.
 Beilke, Clifford A. 815 W. Chicago Ave.
 Benchik, Frank A. 4712 Magoun Ave.
 Bonaventura, Angelo P. 3701 Main St.
 Boyd, Charles S. 4739 Melville Ave.

Boys, Fay F. 4712 Magoun Ave.
 Brauer, Abraham A. 3528 Main St.
 Braun, Benjamin D. St. Catherine's Hospital
 Broomes, Edward L. C. 2402 Broadway
 Bryant, Edward G. 2220 Broadway
 Campagna, Ettro A. 3406 Guthrie St.
 Claybourn, Norman L. 3210 Watling St.
 Dainko, Alfred J. 823 W. Chicago Ave.
 Fleischer, Jacob C. 4035 Elm St.
 Gardiner, H. Glenn. 3210 Watling
 Geronimo, Manuel M. 3502 Main St.
 Geronimo, Rita R. V. 3502 Main St.
 Govorchin, Alexander. 724 W. Chicago Ave.
 Grosso, William G. 1919 E. Columbus Dr.
 Harper, James W. 3912 Euclid
 Hayes, Frank W. 4742 Melville Ave.
 Hayes, Jesse D. 4804 Alexander
 Hernandez, I. C. 3701 Main St.
 Johns, David R. (S) 1211 Beacon St.
 Komoroske, John E. 4710 Indianapolis Blvd.
 Kopanko, Bernard F. 823 W. Chicago Ave.
 Levin, Eli L. 4105 Grand Blvd.
 McGuire, Desmond F. (S) 3429 Michigan Ave.
 Marks, Ora L. 815 W. Chicago Ave.
 Marquinez, Adoracin A. 4124 Elm
 Mella, Ramon E. 3502 Main St.
 Milan, Shisachki D. 622 W. Chicago Ave.
 Moleski, Walter L. 3406 Guthrie
 Nisocia, John B. 1802 E. Columbus Dr.
 Payne, Arthur C. 2020 Broadway
 Ramos, John. 3807 Main St.
 Reitman, Paul H. 4321 Fir St.
 Rodriguez, Cecilio. 3406 Guthrie
 Szazana, Francis J. Inland Steel Co.
 Serna, Jesus A. 3619 Main St.
 Shapiro, Joseph. 3738 Main St.
 Shapiro, Seymour W. 3738 Main St.
 Shulruff, Harry I. 3701 Main St.
 Teegarden, Joseph A., Jr. 1919 E. Columbus Dr.
 Teegarden, Joseph A. (S) 1919 E. Columbus Dr.
 Teplinsky, Louis L. 1802 E. Columbus Dr.
 Trepagnier, Francis B. 3628 Main St.
 Walker, Adolph P. 1820 E. Columbus Dr.
 Wooden, Thomas F. 1820 E. Columbus Dr.
 Yanson, Mannfredo R. S. 4035 Elm St.
 Zallen, Stanley G. 720 W. Chicago Ave.

Gary

Abramson, Allan L. 3290 Grant St.
 Agana, Adriano A. 630 Allen
 Alfano, Paul A. 2717 Wabash
 Almquist, Carl O. 504 Broadway
 Alvarez, Paul. 2717 Wabash Ave.
 Ambrozaitis, Kazys. 1600 W. Sixth Ave.
 Amico, Pasquale J. 3807 Washington
 Angeles, Uldarico A. 504 Broadway
 Armalavage, Leon J. 2620 W. Fifth Ave.
 Atienza, Rizalino T. 638 Fillmore
 Barton, Reginald R. 427 S. Lake
 Behn, Walter M. 504 Broadway
 Bender, Carl H. 3290 Grant St.
 Bergal, Milton B. 738 Broadway
 Bernard, Marvin R. 3807 Washington St.
 Bills, R. James. 504 Broadway
 Bills, Robert N. 504 Broadway
 Bisgyer, Jay L. 400 Broadway
 Boardman, Carl (S) 630 Buchanan St.
 Borak, Walter J. 5000 Ridge Road
 Bornstein, Herschel. 3290 Grant
 Brady, Samuel G. 757 Broadway
 Brandman, Harry. 504 Broadway
 Brincko, John. 504 Broadway
 Bringas, Irineo B. 858 Broadway
 Brink, Calvin C. (S) 504 Broadway
 Brown, David B. 504 Broadway
 Brown, Jesse F. Methodist Hospital
 Brown, Leo R. 4645 Broadway
 Bullard, Mattie J. 620 E. Tenth Place

Burcham, James B.....738 Broadway
 Burger, Robert A.....Methodist Hospital
 Cahué, Antonio R.....504 Broadway
 Carberry, George A.....3656 Grant St.
 Carbone, Joseph A.....504 Broadway
 Carey, J. Albert.....1903 Broadway
 Carmody, Raymond F.....504 Broadway
 Chube, David D.....1606 Broadway
 Cooper, Leo K.....504 Broadway
 Corrao, Gaetano.....2471 Colfax
 Daniel, Robert A.....738 Broadway
 Danielewski, Ladislaus J.....738 Broadway
 Darling, Dorothy.....1600 W. Sixth Ave.
 Davis, Neal.....1600 W. Sixth Ave.
 De Bois, Elon.....1649 Broadway
 Dian, August J.....504 Broadway
 Dierolf, Edward J.....504 Broadway
 Donchess, Joseph C.....215 Broadway
 Dosado, Elpidio B.....3807 Washington
 Duncan, John S.....2165 W. 11th St.
 Elliott, Ralph A.....504 Broadway
 English, Hubert M.....673 Broadway
 Espy, Theodore R.....1901 Broadway
 Fadell, Matthew J.....4655 Broadway
 Fadul, Armand.....5317 W. Fifth Ave.
 Franklin, Philip L.....936 W. 5th Ave.
 Galante, Vincent J.....St. Mary Mercy Hospital
 Gallinatti, John J.....1034 Aetna St.
 Gilles, Pierre.....1804 Broadway
 Glover, William J.....504 Broadway
 Goldberg, Harold B.....3656 Grant
 Golding, Robert F.....P. O. Box 727
 Goldstone, Adolph.....3229 Broadway
 Goldstone, Joseph.....3229 Broadway
 Goldstone, Sidney R.....3233 Broadway
 Grant, Benjamin F.....1706 Broadway
 Gregoline, Amadeo F.....729 Broadway
 Hadey, James H.....2620 W. Fifth Ave.
 Hedrick, James T.....1649 Washington St.
 Hodurski, Zsigmond.....4319 Broadway
 Hoham, Frederick D.....3792 Central, East Gary
 Hoyt, Leonard.....504 Broadway
 Jahns, Albin A.....2318 W. Fifth St.
 Johnson, Arnold L.....1903 Broadway
 Johnson, Lonnie B.....123 W. 21st St.
 Kamen, Jack M.....304 Cleveland Ave.
 Kendrick, Frank J.....504 Broadway
 Khaton, Odessa M.....1649 Broadway
 Kilmer, Warren L.....3792 Central, East Gary
 Klaus, Julius M.....5265 Cleveland
 Kobrin, Meyer W.....3229 Broadway
 Kolettis, John G.....504 Broadway
 Kopcha, Joseph E.....504 Broadway
 Korn, Jerome M.....3290 Grant St.
 Lazo, Vicente R.....756 Broadway
 Lebiada, Henry S.....4655 Broadway
 Lewis, George N.....504 Broadway
 Lewis, Lucien A.....1649 Broadway
 Lipschutz, Harold.....504 Broadway
 Lipsey, Alfred J.....504 Broadway
 Loh, Hwei Ya (Chang).....Methodist Hospital
 Loh, Wei-Ping.....1600 W. Sixth Ave.
 Lorenty, Thaddeus B.....504 Broadway
 Lovell, Martin H.....1606 Broadway
 Lutz, Georgianna.....504 Broadway
 McMath, Samuel B.....1649 Broadway
 Majsterek, Stanley L.....1034 Aetna St.
 Manalo, Francisco M.....538 Lincoln
 Marcus, Morris C.....3229 Broadway
 Marshall, Millard R.....504 Broadway
 Mather, J. Winford.....2250 Ripley St., East Gary
 May, Richard M.....583 Broadway
 Milos, Robert J.....504 Broadway
 Minczewski, Richard C.....5490 Broadway Plaza
 Mitchell, Georgia B.....1706 Broadway
 Molengraff, Cornelius J.....504 Broadway
 Moore, Edwin G.....1606 Broadway
 Morris, Hyman R.....3229 S. Broadway

Moswin, Jack A.....504 Broadway
 Mott, William H.....2009 Broadway
 Nelson, Walfred A.....559 S. Lake St.
 Nilges, Richard G.....2717 Wabash Ave.
 Noonan, Leo C.....3279 Central, East Gary
 Oberlander, Seymour.....3290 Grant St.
 Ornelas, Joseph P.....3656 Grant St.
 Pappas, Eddie T.....2717 Wabash Ave.
 Parratt, Louis W.....708 Broadway
 Penn, Robert A.....3792 Central Ave., East Gary
 Poracky, Bernard F.....504 Broadway
 Pruitt, J. Edward.....4655 Broadway
 Radigan, Leo R.....504 Broadway
 Ramos, Alfonso.....5459 Broadway
 Reynolds, James S.....504 Broadway
 Richter, Samuel.....504 Broadway
 Riordan, John F.....Methodist Hospital
 Robinson, Walter K.....504 Broadway
 Romero, Plinio.....825 W. 11th Ave.
 Rosenbloom, Philip J.....571 Lincoln St.
 Ross, David E., Jr.....633 E. 21st St.
 Roth, Leo.....3229 Broadway
 Roth, Melvin L.....3229 Broadway
 Rubin, Simon S.....504 Broadway
 Ryan, Hubert J.....504 Broadway
 Sala, Joseph J.....2705 Wabash
 Sala, Walter R.....2705 Wabash
 Schmitt, Robert J.....504 Broadway
 Schulz, Kurt J.....4655 Broadway
 Scully, John T.....2318 W. Fifth Ave.
 Senese, Thomas J.....504 Broadway
 Shellhouse, Michael.....3811 Washington St.
 Shevick, Alexander.....2620 W. Fifth Ave.
 Slama, George F.....4431 Broadway
 Slama, John T.....4481 Broadway
 Spellman, Frank W.....401 S. Lake
 Spivack, Mary.....504 Broadway
 Sponder, Joseph (S).....1512 Broadway
 Stern, Mona K.....3830 Central, East Gary
 Stinson, Harry R.....504 Broadway
 Stoycoff, Christ M. (S).....860 Broadway
 Thomas, Daniel D.....3290 Grant St.
 Thomas, Gerald J.....3920 Grant St.
 Trinosky, Frank G.....504 Broadway
 Tsatsos, George C.....3820 Central, East Gary
 Turgi, Robert W.....504 Broadway
 Valencia, M. M.....2620 Central Ave., East Gary
 Verplank, Grover L. (S).....2701 W. 57th Ave.
 Voorhies, McKinley.....1606 Broadway
 Vye, James P.....607 Broadway
 Walters, Eleanor.....602 Broadway
 Washington, G. Kenneth.....1645 Broadway
 Weiskopf, Henry S.....504 Broadway
 Wharton, Russell O. (S).....6559 Ash Place
 Williams, Alexander S.....436 W. 25th St.
 Williams, Edwin D.....436 W. 25th St.
 Williams, Fred.....2501 Polk St.
 Wimmer, Robert N. (S).....9 W. Sixth St.
 Yast, Charles J.....504 Broadway
 Yocum, Paul S., Jr.....504 Broadway
 Yocum, Paul S.....757 Broadway
 Yocum, William S.....790 Broadway
 Young, George M.....3656 Grant St.
 Young, Robert L.....504 Broadway
 Zucker, Edward.....504 Broadway

Griffith

Carpenter, Bennie.....1212 N. Broad
 Lundeberg, Ralph A.....1212 N. Broad St.
 Purcell, Richard J.....433 N. Glenwood
 Siekierski, Joseph M.....145 N. Griffith

Hammond

Allegretti, Michael L.....6850 Hohman Ave.
 Bakos, Edward R.....7016 Indianapolis Blvd.
 Balaguer, Carmen.....20 Kenwood
 Beconovich, Robert.....6850 Hohman Ave.
 Bethea, Dennis A. (S).....1021 Fields St.

Bombar, Leslie E. 6850 Hohman Ave.
 Brenner, Howard B. 6850 Hohman Ave.
 Chael, Thomas C. 6850 Hohman Ave.
 Chidlaw, Benjamin W. (S) 29 Wildwood Rd.
 Clancy, James F. 6223 Hohman Ave.
 Costello, Albert J. 30 Douglas St.
 Cotter, Edward R. 2415 169th St.
 Davis, Alice Hall (S) 264 Highland St.
 Davis, Thomas N. III. 5246 Hohman Ave.
 Eggers, Ernest L. (S) 635 165th St.
 Eggers, Henry W. 30 Douglas St.
 Egnatz, Nicholas. 820 Highland
 Elledge, Ray. 6415 Forest Ave.
 Fischer, Burnell. St. Margaret's Hosp.
 Fitzpatrick, William J. 30 Douglas St.
 Friedman, Isadore E. 7217 Indianapolis Blvd.
 Gevirtz, Milton B. 6850 Hohman Ave.
 Hickman, A. Lee. 7127 Indianapolis Blvd.
 Hopkins, Joseph R. 430 Conkey
 Howard, William Harry. 5231 Hohman Ave.
 Husted, Robert G. 6850 Hohman Ave.
 Hyndman, Lloyd G. 1566 178th Place
 Jones, Eli S. 30 Douglas St.
 Kenney, Francis D. 30 Douglas St.
 Kolanko, Leon A. 30 Douglas St.
 Koransky, David S. 7217 Indianapolis Blvd.
 Kuhn, Arthur J. 112 Rimbach St.
 Kuhn, Hedwig S. 112 Rimbach St.
 LaFollette, Forrest R. 7016 Indianapolis Blvd.
 Lautz, Herbert A. 112 Rimbach St.
 Long, Keith J. 30 Douglas St.
 McVey, Clarence A. 5231 Hohman Ave.
 Mansueto, Mario D. 5231 Hohman Ave.
 Marcus, Emanuel. 7127 Indianapolis Blvd.
 Marks, Salvo P. 30 Douglas St.
 Mason, John C. 6850 Hohman Ave.
 Mason, Richard L. 132 Rimbach St.
 Mintz, Alfred M. 7550 Hohman Ave.
 Modjeski, Joseph R. 5451½ Hohman Ave.
 Montes, Herminio Y. 5217 Hohman Ave.
 Neal, Leonard W. 6850 Hohman Ave.
 Nodinger, Louis. 540 165th St.
 Palmer, Barron M. F. 6134 Columbia
 Panares, Solomon V. 5434 Hohman Ave.
 Peck, Edward A. 430 Conkey St.
 Peiffer, Geraldine M. 5217 Hohman Ave.
 Pilot, Jean. 5231 Hohman Ave.
 Portney, Fred R. 6850 Hohman Ave.
 Premuda, Franklin F. 6727 Kennedy Ave.
 Ramker, Daniel T. 7040 Kennedy Ave.
 Rasch, George C., Jr. 8148 Calumet
 Rawlins, Carolyn M. 6223 Hohman Ave.
 Remich, Antone C. 30 Douglas St.
 Rendel, Donald T. 5231 Hohman Ave.
 Repay, Walter A. 25 Douglas St.
 Rhind, Alexander W. 422 Conkey St.
 Rosenthal, Carl. St. Margaret's Hospital
 Rosevear, Henry J. 30 Douglas St.
 Row, Perrie Q. 7217 Indianapolis Blvd.
 Rubright, Robert L. 7025 Monroe St.
 Santiago, Iluminada. 2804 Duluth
 Sargent, Wallace B. 112 Rimbach
 Schlesinger, Daniel J. 6850 Hohman Ave.
 Schulfer, Richard J. 7134 Calumet Ave.
 Schwartz, Jack. 30 Douglas St.
 Schwartz, Mary M. 25 Douglas St.
 Shecter, Harry. 25 Douglas St.
 Smith, Jerald E. 6850 Hohman Ave.
 Smitley, Roger P. 30 Douglas St.
 Snyder, Jerome A. 6850 Hohman Ave.
 Solis, Roger V. 422 Conkey St.
 Sroka, Alexander G. 5305 Hohman Ave.
 Stasick, Murray. 837 169th St.
 Stern, Samuel L. 5231 Hohman Ave.
 Stevens, Edwin W. 6850 Hohman Ave.
 Sweany, Stanford. 5231 Hohman Ave.
 Thomas, Thomas R. 60 Douglas St.

Tilka, Edward C. 7134 Calumet
 Trachtenberg, Lee. 112 Rimbach
 Weissman, Charles G. 5246 Hohman Ave.
 White, Gilbert H. Jr. 6429 Kennedy Ave.
 Wong, Samuel N. 7127 Indianapolis Blvd.

Highland

Sroka, Stanley J. 2942 Highway Ave.
 Vore, Hugh A. 8680 Prairie Ave.

Hobart

Bjorklund, C. Ray. 295 S. Wisconsin St.
 Bradley, Charles F. 701 W. Ridge Rd.
 Carter, John O. 295 S. Wisconsin St.
 Faulkner, Donald J. 295 S. Wisconsin St.
 Kellar, Philip E. 295 S. Wisconsin St.
 Klos, Stanley J. 10 N. Michigan Ave.
 Krsek, Archie J. 10 N. Michigan Ave.
 Markle, Joseph G. 201 Main St.
 Parker, Harry C. (S) 831 Garfield St.
 Pike, Warren H. 108 E. Third St.
 Reed, John. 10 N. Michigan Ave.
 Weiss, John T. 295 S. Wisconsin St.

Lowell

Smith, Robert D. 308 E. Commercial
 Templin, David B. 308 E. Commercial

Munster

Arbeiter, Herbert L. 7550 Hohman Ave.
 Arrowsmith, James L. 7550 Hohman Ave.
 Egnatz, Charles D. 223 Terrace Dr.
 Espino, Jose C. 8144 Calumet Ave.
 Fox, Jack M. 7550 Hohman Ave.
 Lanman, John U. 8146 Calumet Ave.
 Larrabee, James F. 130 Ridge Road
 Madlang, Rodolfo M. 7750 Hohman Ave.
 McLean, James S. 1836 Ridge Road
 Navarre, Vincent J. 7628 Manor Ave.
 Paul, Eudell G. 7550 Hohman Ave.
 Rudolph, Franklin G. 7550 Hohman Ave.
 Santare, Vincent J. 7550 Hohman Ave.
 Westhaysen, Peter V. 7550 Hohman Ave.

Whiting

Angel, Virgil E. 2125 Indianapolis Blvd.
 Becker, Samuel W. 1900 Indianapolis Blvd.
 Best, Robert C. 1900 Indianapolis Blvd.
 Ferry, John L. 1902 Indianapolis Blvd.
 Frankowski, Clementine E. 1907 New York Ave.
 Greisen, Jack G. 1902 Indianapolis Blvd.
 Gustaitis, John W. 1900 Indianapolis Blvd.
 Kaiser, George D. 1900 Indianapolis Blvd.
 Kudele, Louis T. 1321 119th St.
 McCarthy, Jeremiah A. 1341 119th St.
 Polite, Nicholas L. 1900 Indianapolis Blvd.
 Rudser, Donald H. 1902 Indianapolis Blvd.
 Silvian, Harry A. 1010 119th St.
 Smith, Theodore J. 1902 Indianapolis Blvd.
 Sokol, Allen B. 1900 Indianapolis Blvd.
 Stecy, Peter. 1902 Indianapolis Blvd.
 Steen, Lowell H. 1900 Indianapolis Blvd.
 Troy, Jack M. 1900 Indianapolis Blvd.
 Weinberg, Benjamin A. 1346 119th St.

Bolin, John T. (S) Mountain Home, Ark.
 Detrick, Herbert W. (S)
 4845 Northwood Ave., Sarasota, Fla.
 Feldner, Ronald P.
 17717 S. Bernadine, Lansing, Ill.
 Goodell, Charles L.
 2378 Ewald Circle, Detroit 38, Mich.
 Hayes, Jesse D., Jr.
 4143 A San Francisco, St. Louis, Mo.
 Jannasch, Maurice C.
 3022 Landria Dr., Richmond 25, Va.
 Kmak, Chester J. 19447 Orleans, Detroit, Mich.
 McMichael, Frank J. (S) Box 277, Hernando, Fla.

Murphy, Joseph F. 3508 Ridge Rd., Lansing, Ill.
 Seyler, Anna G. 2780 Hillcrest Dr., La Verne, Calif.
 Tyrrell, Joseph J. 800 State Line, Calumet City, Ill.
 Tyrrell, Thomas C. 800 State Line, Calumet City, Ill.

LA PORTE COUNTY

Oak, David, Jr. Hanna
 Oak, David D. (S) LaCrosse

La Porte

Backer, George P. 806 Maple Ave.
 Backer, Mary B. 1533 Michigan Ave.
 Carpentier, James R. 903 Indiana Ave.
 Carter, Fred S. 912 Indiana Ave.
 Cartwright, Jack D. 1003 Indiana Ave.
 Datzman, Basil J. 216 E Street
 Durham, Lowell J. 1012 Harrison St.
 Elshout, Clem H. 1004 Indiana Ave.
 Erwin, W. Robert 216 "E" St.
 Fargher, Robert A. 811 Jefferson Ave.
 Farnsworth, Samuel A. 1012 Michigan Ave.
 Feinn, Harry S. 1013 Indiana Ave.
 Fischer, Carlton N. 1001 Maple Ave.
 Kelsey, Robert M., Jr. 702 Maple Ave.
 Kelsey, Robert M., Sr. 702 Maple Ave.
 Kepler, Robert W. 708 Harrison St.
 Kistler, James J. 911 Maple Ave.
 Larson, Goyt O. 1110 Indiana Ave.
 Mead, Frank E. 801 Madison St.
 Mueller, Edwin C. 905 Indiana Ave.
 Muhleman, Charles E. 901 Indiana Ave.
 Philbrook, Seth S. 705 Harrison St.
 Predd, Adolph C. 909 Madison St.
 Richter, John C. 1110 Indiana Ave.
 Scott, John S. 806 Maple Ave.
 Tabaka, Francis B. 1201 Michigan Ave.
 Von Asch, George 912 Monroe St.
 Wolf, William E. 102 Lincoln Way

Michigan City

Armstrong, Thomas D. 120 W. Ninth St.
 Arney, Amos 125 E. Fifth St.
 Baker, Warren 427 Warren Bldg.
 Bankoff, Milton L. 125 E. Fifth St.
 Bergan, Joseph A. 719 Franklin
 Berkson, Myron E. 801 Washington St.
 Burris, Floyd L. 731 Spring St.
 Carlson, Norman R. 913 Wabash St.
 Cleveland, John B. 2222 E. Michigan St.
 Fargher, Francis M. 907 Washington St.
 Frost, Robert J. 817 Pine St.
 Gardner, Melvin D. 801 Washington St.
 Gardner, Russell A. 801 Washington St.
 Gilmore, Robert W. 304 Warren Bldg.
 Gilmore, Russell A. 304 Warren Bldg.
 Grotts, Bruce F. 2110 Oriole Trail, Long Beach
 Henderson, Norman C. 131 E. Eighth St.
 Hillenbrand, Charles 128 W. 10th St.
 Hoffman, Kenneth C. 817 Pine St.
 Jones, King S. 328½ Franklin St.
 Kemp, John T. 122 E. Seventh St.
 Kerr, Charlotte H. 723 Franklin St.
 Kerr, John E. 507 Warren Bldg.
 Kerrigan, John F. 916 Washington St.
 Kerrigan, Robert L. (S) 916 Washington St.
 Kubik, Francis J. 902 Pine St.
 Liddell, Charles K. 916 Washington St.
 Marske, Robert L. 311-13 Warren Bldg.
 McGue, Frank J. P. O. Box 41
 Miller, Maurice 125 E. Fifth St.
 Milne, Walter S. 916 Washington St.
 O'Brien, Raymond J. 1412 Franklin St.
 Olson, William H. 509 Willard Ave.
 Paul, Leonard G. 515 Pine St.
 Phillips, John H. 120 W. Ninth St.
 Pilecki, Peter J. 125 E. Fifth St.

Plank, C. Robert 732 E. Pine St.
 Reed, Nelle C. (S) 3210 Tilden Ave.
 Stumer, Myer 1412 Franklin St.
 Taub, Robert G. 125 E. Fifth St.
 Tunnell, Harry D. 107 W. Fourth St.
 Walters, William H. Warren Bldg.
 Warren, Lewis T. 2936 Belle Plaine
 Weeks, Patrick H. (S) 119 E. Sixth St.
 Weiss, Albert E. 125 E. Fifth St.
 Zalac, Donald A. 732 Pine St.

Helmen, Harry W. (S) Rolling Prairie
 Weinstock, Adolph Rolling Prairie
 Moosey, Louis Union Mills
 Benz, Owen F. Wanatah

Westville

Constan, Evan Beatty Memorial Hospital
 Dieter, William J. Beatty Memorial Hospital
 Hetman, Mitchell J. Westville
 Johnston, Donald D. (S)

Beatty Memorial Hospital
 Matthew, John R. Beatty Memorial Hospital
 Meyer, Hans Beatty Memorial Hospital
 Morton, David P. Beatty Memorial Hospital
 Oster, Jack H. Beatty Memorial Hospital
 Salzburg, Herbert E. Beatty Memorial Hospital
 Sennett, Cecil M. (S) Beatty Memorial Hospital
 Smith, William M. Beatty Memorial Hospital
 Wygant, Marion D. Beatty Memorial Hospital

LAWRENCE COUNTY

Bedford

Allen, L. Howard 1622 24th St.
 Austin, Richard P. 209 Citizens Nat'l Bank Bldg.
 Benham, Lawrence E. 310 Stone City Bank Bldg.
 Bridwell, Edgar 1626 24th St.
 Campbell, William T. 2900 W. 16th St.
 Duncan, Raymond 2900 W. 16th St.
 Dusard, Joseph C. 304 Citizens Nat'l Bank Bldg.
 Edmonds, Kendrick 1303 15th St.
 Emery, Charles B. 1027 15th St.
 Fahringer, Robert R. 2900 W. 16th St.
 Fey, Charles W. 2900 W. 16th St.
 Fountaine, Thomas J. 2900 W. 16th St.
 Hammel, Howard T. 1501 J St.
 Hawkins, Richard D. 2900 W. 16th St.
 Kasting, Gerald 206 Citizens Nat'l Bank Bldg.
 Kerr, Donald M. 2900 W. 16th St.
 Manzanero, Fortunato M. 2900 W. 16th St.
 Morrow, Robert J. 1317 L St.
 Newland, Arthur E. Masonic Temple
 Noe, William R. 2900 W. 16th St.
 Robinson, William H. 2900 W. 16th St.
 Scherschel, John P. 1711 H St.
 Waldo, Guy H. 2900 W. 16th St.
 Wohlfeld, Julius B. 1222 15th St.
 Woolery, Richard H. 1310 W. 16th St.
 Wynne, Roland E. (S) 1310 W. 16th St.

Hamilton, James R. Mitchell
 Oswalt, James T. Mitchell

MADISON COUNTY

Alexandria

Gaunt, Everett W. 214 E. John
 Leroy, Alvin G. 1309 N. Harrison St.
 McClelland, Harry N. 118 E. Church St.
 Overpeck, George H. 313 N. Harrison St.
 Owen, Thomas F. 313 N. Harrison St.
 Shafer, Richard H. 111 S. Harrison St.

Anderson

Aagesen, Walter J. 702 Citizens Bank Bldg.
 Armington, Charles L. 655 Anderson Bank Bldg.
 Armington, Robert L. 1504 Broadway

Austin, Charles E.....1612 Westwood Ave.
 Baughn, William L.....Guide Lamp
 Beeler, Franklin K.....1931 Brown St.
 Bixler, Donald P.....1931 Brown St.
 Blassaras, Chris.....2005 Broadway
 Bowers, Charles R.....207 Anderson Loan Bldg.
 Brauchla, Carl H. (S).....117 W. 17th St.
 Bridges, Alvin.....1302 Madison Ave.
 Brock, Earl E. (S).....931 Meridian St.
 Buckles, David L.....St. John's Hospital
 Dixon, Rex W.....934 W. 8th St.
 Doenges, James L.....1931 Brown St.
 Donaldson, Frank C.....1931 Brown St.
 Drake, James R.....229 Citizens Bank Bldg.
 Drake, John C.....604 Anderson Bank Bldg.
 Drennen, Robert V.....318 Rangeline Road
 Dulin, Basil B.....St. John's Hospital
 Ellis, Seth W.....717 Anderson Bank Bldg.
 Elsten, Aubrey W.....512 Anderson Bank Bldg.
 Faust, Howard M., Jr.....315 Anderson Bank Bldg.
 Ferguson, Donald H.....402 Anderson Bank Bldg.
 Fischer, Warren E.....St. John's Hospital
 Gante, Henry W. (S).....2005 Nichol Ave.
 Hart, William D.....126 W. 12th St.
 Hensler, Benton M.....1709 Nichol Ave.
 Irwin, Seth (S).....2209 Cedar St.
 Jarrett, Paul E.....315 Citizens Bank Bldg.
 Jones, Albert T.....1307 Park Road
 Jones, David G.....126 W. 12th St.
 Jones, Horace E.....1110 Meridian St.
 Kelly, Wendell C.....704 E. Eighth St.
 Kiely, John T.....1931 Brown St.
 King, Joseph W.....1110 N. Meridian St.
 Kopp, Otis A.....333 Jackson St.
 Kopp, William R.....333 Jackson St.
 Lamey, James L.....447 Citizens Bank Bldg.
 Lamey, Paul T.....423 Citizens Bank Bldg.
 Land, Richard N.....523 Citizens Bank Bldg.
 Larmore, Joseph L.....612 Anderson Bank Bldg.
 Larmore, Sarah H.....1301 Winding Way
 Litzenger, Sam W.....610 Citizens Bank Bldg.
 Long, Paul L.....710 Anderson Bank Bldg.
 McDonald, Virgil G. (S).....1110 Meridian St.
 Meister, Doris (S).....315 W. 9th St.
 Moneyhun, James E.....621 Citizens Bank Bldg.
 Morris, Robert A.....1309 Park Road
 Neale, Alfred E.....1931 Brown St.
 Nesbit, Leonard L.....415 Citizens Bank Bldg.
 Patterson, William K.....713 Anderson Bank Bldg.
 Pierce, Frederick H.....Delco Remy Div.
 Polhemus, Warren C.....1803 Pearl St.
 Quickel, Daniel S. (S).....608 Central Way
 Reed, Roger R.....412 Anderson Bank Bldg.
 Rosenbaum, Lloyd E.....647 Citizens Bank Bldg.
 Ross, Guy E.....1931 Brown St.
 Rozelle, Clarence V.....611 Citizens Bank Bldg.
 Sharp, William L.....449 Citizens Bank Bldg.
 Sheldon, Suel A.....508 Anderson Bank Bldg.
 Stamper, Joseph H.....412 Anderson Bank Bldg.
 Stamper, Robert J.....412 Anderson Bank Bldg.
 Starks, William O.....507 Citizens Bank Bldg.
 Stinson, William M.....333 Jackson St.
 Swan, Richard C.....Delco Remy
 Wagoner, John R.....708 Anderson Bank Bldg.
 Webb, Harry D.....515 Citizens Bank Bldg.
 Weiss, Louis L.....1225 N. Madison
 Wilder, Gordon B.....338 W. Eighth St.
 Williams, Francis M.....1132 Central Ave.
 Williams, Robert H.....1132 Central Ave.
 Wright, Cecil S.....207 Beverly Terrace

Elwood

Buechler, William F.....1817 S. A St.
 Drake, Marion C.....1201 Main St.
 Fitzpatrick, Harry W. (S).....1309 S. Anderson St.

Hanson, Martin F.....1102 S. Anderson St.
 Hoppenrath, William H. (S).....1300 Main St.
 Laudeman, Walter A.....1515 N. A St.
 Oldag, George E.....1301½ Main St.
 Ploughe, Ralph R.....517 S. Anderson St.
 Scea, Wallace A.....1601 S. Anderson St.
 Ulrey, Robert P.....1201 Main St.

Bishop, Harry A.....Frankton
 Ridgway, Alton H.....Lapel
 Rinne, John I. (S).....Lapel
 Williams, Robert D.....Markleville
 Advincula, Luis.....Box 28, Pendleton
 Bogmenko, Leon T.....Box 28, Pendleton
 Leahy, Howard J.....103 E. State St., Pendleton
 McLaughlin, Calvin P.....200 W. State St., Pendleton
 Van Ness, William C.....Summitville

MARION COUNTY

Beech Grove

Berger, Morley.....902 Main St.
 Christie, Marvin C.....3655 S. Sherman Dr.
 Dill, Charles W.....3655 S. Sherman Dr.
 Kim, Young D.....136 N. 17th St.
 Ramage, Walter F.....244 S. First St.
 Reilly, Eva F.....St. Francis Hospital
 Rhea, James C.....801 Main St.
 Zervas, Charles P. A.....926 Main St.

Hade, Frederick L. (S)
 8925 W. Washington St., Bridgeport
 Zervas, Leon G.....R.R. 1, Camby
 Garrison, James L.....11890 Welland St., Cumberland

Indianapolis

A

Abreu, Benedict E.
 Pitman-Moore Co., 1200 Madison Ave. (6)
 Addleman, Robert H.....5540 Woodside Dr. (8)
 Adkins, Harold C.....409 E. 30th St. (5)
 Akre, Philip R.....Marion Co. General Hospital (7)
 Albertson, Frank P.....3544 W. 16th St. (22)
 Aldrich, Harry D.....201 Hume Mansur Bldg. (4)
 Aldrich, Howard.....4316 E. Washington St. (1)
 Alexander, Ezra D.....617 Indiana Ave. (2)
 Allen, Donald R.....Marion Co. General Hospital (7)
 Allen, Robert K.....3202 N. Meridian St. (8)
 Alvis, Edmond O.....320 Hume Mansur Bldg. (4)
 Anderson, James W.....623 N. West St. (2)
 Anderson, John T.....3349 Georgetown Rd. (24)
 Anderson, Wendell C.

Indiana State Board of Health, 1330 W. Michigan St. (7)

Anshutz, William M.....313 Hume Mansur Bldg. (4)
 Antreasian, Berj.....4829 E. 38th St. (18)
 Appel, Richard H.....320 Hume Mansur Bldg. (4)
 Arbogast, John L.....I. U. Medical Center (7)
 Arbuckle, William E. (S).....1150 S. Sheffield (21)
 Armer, Robert M.....Riley Hospital (7)
 Armstead, John W.....2140 N. Capitol Ave. (2)
 Arnold, Aaron L.....607 E. 38th St. (5)
 Arnold, Robert D.....3419 E. 10th St. (1)
 Aronson, Sidney S.....618 Hume Mansur Bldg. (4)
 Aust, Charles H.....1119 N. Linwood (1)
 Avery, George O.....17 S. Traub (22)

B

Bachmann, Arnold J.....3440 N. Meridian St. (8)
 Badenhauer, Walter E., Jr.
 St. Vincent's Hospital (7)
 Baird, Melvin S.....17½ W. 22nd St. (2)
 Bakemeier, Otto H.....5503 E. Washington St. (19)
 Bakemeier, Robert E.
 Marion Co. General Hospital (7)
 Balch, James F.....709 Hume Mansur Bldg. (4)
 Ball, Joseph E.....4312 E. 10th St. (1)

Banister, Revel F. (S).....2958 Central Ave. (5)
 Banks, Horace M. (S)
 3631 Forest Manor Ave. (18)
 Baptisti, Arthur, Jr.
 Marion Co. General Hospital (7)
 Barden, Tom P. Marion Co. General Hospital (7)
 Barrett, Robert V.....Methodist Hospital (7)
 Barry, Maurice J. (S).....501 Doctors' Bldg. (4)
 Bartle, James L.....7450 Pendleton Pike (26)
 Bartley, Max D.....607 Hume Mansur Bldg. (4)
 Barton, David M.....I. U. Medical Center (7)
 Bastnagel, William F....3602 N. Meridian St. (8)
 Batman, Gordon W....723 Hume Mansur Bldg. (4)
 Battersby, J. Stanley...I. U. Medical Center (7)
 Batties, Paul A.....617 Indiana Ave. (2)
 Bauer, Thomas B....408 Hume Mansur Bldg. (4)
 Baumeister, Herbert E.....4421 E. 75th St. (20)
 Baxter, John P.....1633 N. Capitol Ave. (2)
 Beach, Robert R.....2630 E. 10th St. (1)
 Beamer, Parker R.....I. U. Medical Center (7)
 Beaver, Howard W.....8 E. Troy (3)
 Beck, Evert M.....915 E. 38th St. (2)
 Becker, Harry G.....6060 College Ave. (20)
 Beeler, John W.....712 Hume Mansur Bldg. (4)
 Beeler, Raymond C. (S)
 712 Hume Mansur Bldg. (4)
 Behnke, Roy H....VA Hosp., 1481 W. 10th St. (7)
 Belshaw, George.....5317 E. 16th St. (18)
 Belt, James H.....6225 Broadway (20)
 Benedict, Paul F.....3941 Meadows Dr. (5)
 Bennett, Ivan F.
 Lilly Clinic, Marion Co. General Hospital (7)
 Berman, Edward J....920 Hume Mansur Bldg. (4)
 Berman, Jacob K....920 Hume Mansur Bldg. (4)
 Beverland, Malon E. (S)
 3036 E. Washington St. (1)
 Bibler, Lester D.....811 Underwriters Bldg. (4)
 Bill, Robert O.....2901 N. Meridian St. (8)
 Bird, Charles R. (S)...3758 N. Pennsylvania St. (5)
 Black, Henry R....Marion Co. General Hospital (7)
 Blackford, Florence.....5909 E. 10th St. (19)
 Blackford, Ralph E.....5909 E. 10th St. (19)
 Blackwell, Donald S....2121 Allison Ave. (24)
 Blake, Albert L.....1802 N. Illinois St. (2)
 Blatt, A. Ebner.....3400 N. Meridian St. (8)
 Bloemker, Edward F.....2729 Shelby St. (3)
 Boggs, Eugene F.....2901 N. Meridian St. (8)
 Boling, Frederick F.....Methodist Hospital (7)
 Boling, Grover C., Jr....1440 E. 46th St. (5)
 Bomalaski, Martin D....5538 N. Keystone Ave. (20)
 Bond, George S. (S)....1221 N. Delaware St. (2)
 Bond, Virginia.....R. 17, Box 364 (23)
 Bond, William H.....I. U. Medical Center (7)
 Bonsett, Charles A....902 Hume Mansur Bldg. (4)
 Booher, Norman R.....447 E. 38th St. (5)
 Booher, Olga Bonke.....447 E. 38th St. (5)
 Booker, Harold E.....Riley Hospital (7)
 Booth, Boynton H....707 Hume Mansur Bldg. (4)
 Booze, James.....Marion Co. General Hosp. (7)
 Bowers, George W.....Methodist Hospital (7)
 Bowers, John A....Marion Co. General Hospital (7)
 Bowman, George W. (S)....1101 W. 10th St. (7)
 Boyer, Floyd A.....442 N. Drexel Ave. (1)
 Brady, Thomas A....818 Hume Mansur Bldg. (4)
 Brayton, John R....704 Underwriters Bldg. (4)
 Brayton, Lee.....3342 N. Illinois St. (8)
 Brickley, Harry D....605 Hume Mansur Bldg. (4)
 Brickley, Richard A....605 Hume Mansur Bldg. (4)
 Briggs, Robert W.....2140 N. Capitol (2)
 Brillhart, James R....3120 N. Meridian St. (8)
 Brodie, Donald W.....817 C. of C. Bldg. (4)
 Brooks, Fred R., Jr....3349 Georgetown Rd. (24)
 Brose, Paul E.....Marion Co. General Hospital (7)
 Brown, Archie E.....1220 S. Belmont Ave. (21)
 Brown, David E.....1944 N. Capitol Ave. (2)
 Brown, DeWitt W.....1633 N. Capitol Ave. (2)
 Brown, Frances T.....2126 N. Talbot Ave. (2)

Brown, Frank M.....2875 Clifton (23)
 Brown, Gordon T.....3989 Meadows Drive (5)
 Brown, Thomas C.....Methodist Hospital (7)
 Brown, Wendell E.....3426 N. Meridian St. (8)
 Browning, James S.....2901 N. Meridian St. (8)
 Browning, William M....3426 N. Meridian St. (8)
 Brownley, Emma J.....5101 W. 13th St. (24)
 Bruce, Reginald A.....848 Indiana Ave. (2)
 Brucekman, F. Robert
 Marion Co. General Hospital (7)
 Bruetsch, Walter L....3000 W. Washington St. (22)
 Burdette, Harold F.....3202 N. Meridian (8)
 Burghard, Rolla D.....4829 E. 38th St. (18)
 Burkle, Robert J.
 Marion Co. General Hospital (7)
 Butler, John O.....234 E. Southern Ave. (25)
 Butler, Robert M.....3426 N. Meridian St. (8)

C

Cahn, Hugo M.....418 E. 30th St. (5)
 Caldwell, Marilyn R.....111 E. 53rd St. (20)
 Call, Herbert F.....2901 N. Meridian (8)
 Calvert, John H., Jr....4450 Guilford (5)
 Campbell, H. Edwin, Jr..St. Vincent's Hospital (7)
 Campbell, John A.....I. U. Medical Center (7)
 Campbell, Robert L....1100 W. Michigan St. (7)
 Canaday, James W. (S)....5154 Central Ave. (5)
 Capestany, Max A.....St. Vincent's Hospital (7)
 Caplin, Irvin.....3120 N. Meridian St. (8)
 Caplin, Samuel S.....4525 Indianola (5)
 Carlson, Milton R.
 Marion Co. General Hospital (7)
 Carson, Wayne.....1802 N. Illinois St. (2)
 Carter, James E.....I. U. Medical Center (7)
 Carter, Oren E.....668 E. 38th St. (5)
 Chattin, William R.....4829 E. 38th St. (18)
 Chen, Ko Kuei
 Eli Lilly & Co., 740 S. Alabama St. (6)
 Chernish, Stanley M.
 Marion Co. General Hospital (7)
 Chevalier, Robert A.
 Marion Co. General Hospital (7)
 Childress, Richard H....I. U. Medical Center (7)
 Chivington, Paul V....407 Hume Mansur Bldg. (4)
 Christiansen, Philip A.
 V. A. Hosp., 1481 W. Tenth St. (7)
 Chroniak, Walter....5508 E. Washington St. (19)
 Clark, Cecil P.....922 Hume Mansur Bldg. (4)
 Clark, George A.....922 Hume Mansur Bldg. (4)
 Clark, Lawson J.....3736 N. Delaware St. (5)
 Clevinger, William G.....1610 Auburn St. (24)
 Close, W. Donald.....I. U. Medical Center (7)
 Coates, Jacqueline.....2060 N. Senate Ave. (2)
 Coddington, Robert C.....Riley Hospital (7)
 Coggeshall, Warren E.
 1015 Hume Mansur Bldg. (4)
 Cohn, Alvin F.....1120 Southview Dr. (27)
 Collins, Hubert L....985 N. Arlington Ave. (19)
 Collins, Robert C.....3414 Clifton (23)
 Conley, Joseph L. (S)...2443 E. Washington St. (1)
 Conway, Chester C....4402 E. New York St. (1)
 Conway, Glenn.....1620 S. East St. (25)
 Cornacchione, Matthew.....814 S. East St. (25)
 Cortese, James V.....435 S. East St. (25)
 Cortese, Thomas A.....435 S. East St. (25)
 Costin, Robert L.....I. U. Medical Center (7)
 Couch, Rex D.....1100 W. Michigan St. (7)
 Coughenour, J. Robert...2809 S. Holt Road (41)
 Countryman, Frank W....3233 N. Meridian St. (8)
 Cox, Clifford E. (S)....1950 W. 71st St. (8)
 Craft, Kenneth L....1002 Hume Mansur Bldg. (4)
 Crawford, John A....321 Hume Mansur Bldg. (4)
 Cregger, Irby E....Marion Co. General Hospital (7)
 Cripe, Jerome H.....I. U. Medical Center (7)
 Cross, David G.....1002 Troy Ave. (3)
 Culbertson, Clyde G.
 Eli Lilly & Co., 740 S. Alabama St. (6)
 Cullen, Paul K.....422 Hume Mansur Bldg. (4)
 Culloden, William G.....710 E. 46th St. (5)

Cunningham, Gene C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cure, Charles W.....315 Hume Mansur Bldg. (4)
Currie, Robert W.....512 E. 57th St. (20)
Curry, R. Louis.....3375 Forest Manor (18)
Cuthbert, Marvin P.....3400 N. Meridian (8)
Czenkusch, Helen G.....5101 W. 13th St. (24)

D

Daley, Edward H.....1502 N. Emerson (18)
Dallas, Fred R.....5317 E. 16th St. (18)
Dallas, Mary E.

V. A. Hospital, 1481 W. 10th St. (7)

Dalton, William W.....422 Hume Mansur Bldg. (4)
Daly, Joseph M.....234 E. Southern Ave. (25)
Daniel, John C.....1008 Hume Mansur Bldg. (4)
Dann, Morton W.....I. U. Medical Center (7)
Davidson, Dale A.....1802 N. Illinois St. (2)
Davidson, N. Cort.....3233 N. Meridian St. (8)
Davis, Bennie L.....2426 Northwestern Ave. (23)
Davis, John A.....3720 N. Sherman Dr. (18)
Davis, Margaret M.....Methodist Hospital (7)
Davis, Sam J.....908 Hume Mansur Bldg. (4)
Deal, Eleanor H.....4909 W. 15th St. Speedway (24)
Dearmin, Robert M.....3233 N. Meridian St. (8)
DeArmond, Murray...723 Hume Mansur Bldg. (4)
Deever, John W.....4131 Shelby St. (3)
Deitch, Robert D.....5320 Penway St. (24)
DeMotte, C. Bowen.....808 C. of C. Bldg. (4)
Dennison, Alfred D., Jr. 3400 N. Meridian St. (8)
Denny, Forrest L.....3351 W. 10th St. (22)
Denny, James W.....25 N. Ritter Ave. (19)
Des Jean, Paul A.....4301 E. 38th St. (18)
DeWees, Dwight L.....302 N. Bradley Ave. (1)
DeWester, Gerald M.....3037 S. Meridian St. (27)
Dickson, Carolyn L.....501 N. West St. (2)
Dill, Myron K.....3120 N. Meridian St. (8)
Dilts, Robert L.....2521 E. 38th St. (18)
Dintaman, Paul G.....703 Hume Mansur Bldg. (4)
D'luzansky, James J.....I. U. Medical Center (7)
Donahue, James M.....I. U. Medical Center (7)
Donato, Albert N.....1429 Shelby St. (3)
Doneff, Ronald H. Marion Co. General Hospital (7)
Doran, J. Hal.....720 Hume Mansur Bldg. (4)
Dorman, Willis L.....6430 E. Washington St. (19)
Doss, Jerome F. Marion Co. General Hospital (7)
Doty, James R. Jr.

Marion Co. General Hospital (7)

Doughty, Samuel R., Jr.

5817 N. Dearborn St. (20)

Dowd, Joseph A.....6177 College Ave. (20)
Drew, Arthur L. Jr.....I. U. Medical Center (7)
Dryden, Gale E.....5835 N. Tacoma (20)
Duncan, Stuart J.....3037 S. Meridian St. (27)
Duncan, William A.....3041 Lafayette Rd. (22)
Dupes, Lowell E.

V. A. Regional Office, 36 S. Penn. St. (4)

Dupler, Lee F. W.....Methodist Hospital (7)
Dyar, Edwin W.....3202 N. Meridian St. (8)
Dyke, Richard W. Marion Co. General Hospital (7)
Dzenitis, Andrievs J.....Methodist Hospital (7)

E

Earp, Evanson B.....717 Hume Mansur Bldg. (4)
Eastman, Joseph R., Jr.

514 Merchants National Bank Bldg. (4)

Eaton, Edwin R.....5505 N. Keystone Ave. (20)
Eaton, Lyman D.....5505 N. Keystone Ave. (20)
Ebert, J. Wayne.....1125 Southview Dr. (27)
Eberwein, John H. (S)....2322 Wheeler Ave. (18)
Egbert, Herbert L.....5317 E. 16th St. (18)
Eicher, Palmer O.....3400 N. Meridian St. (8)
Eikenberry, Hugh W...616 Bankers Trust Bldg. (4)
Eldridge, Gail E.....1440 E. 46th St. (5)
Elkins, James P.....234 E. Southern Ave. (25)
Ellis, William N.....1402 N. Olney St. (1)
Emhardt, John T.....1621 S. East St. (25)
Emhardt, John W. A. (S)

5424 Washington Blvd. (20)

Ensminger, Leonard A. (S)

1321 N. Meridian St. (2)

Ericson, Homer S.....Methodist Hospital (7)
Evans, Frederick H.....2140 N. Capitol (2)
Evans, Paul V.....Marion Co. General Hospital (7)
Everly, Ralph V.....668 E. 38th St. (5)

F

Failey, Robert B.....I. U. Medical Center (7)
Farrell, Joseph T.....2807 E. Michigan St. (1)
Fausset, C. Basil.....2901 N. Meridian St. (8)
Ferry, Francis A.....1429 Shelby St. (3)
Fiederlein, Frederick J...I. U. Medical Center (7)
Fiedler, Howard W.....I. U. Medical Center (7)
Finneran, Joseph C.....1802 N. Illinois St. (2)
Fisch, Charles... Marion Co. General Hospital (7)
Fischer, A. Alan.....1745 Howard St. (21)
Fisher, Frank C. Marion Co. General Hospital (7)
Fitzgerald, William J.

303 Fountain Square Theatre Bldg. (3)

Flanagan, Paul M.....3311 N. Meridian St. (8)
Flanders, Robert J.....3202 N. Meridian St. (8)
Flanigan, Meredith B.....3305 Rutledge (8)
Fleisch, Herbert.....Central State Hospital (22)
Flick, John J.....1443 N. Pennsylvania St. (2)
Flora, Joseph O.....4317 W. Washington St. (21)
Folkening, Norval C....234 E. Southern Ave. (25)
Forbes, Robert S.....3043 S. Holt Rd. (4)
Forry, Frank (S).....I. U. Medical Center (7)
Fortuna, Frank W.....5602 S. Madison Ave. (27)
Foster, Lee N.....St. Vincent's Hospital (7)
Foster, Ray D.....1944 N. Capitol Ave. (2)
Fouts, Dallas B.....I.U. Medical Center (7)
Fouts, Paul J.....623 Hume Mansur Bldg. (4)
Franklin, William L...508 Hume Mansur Bldg. (4)
Freed, Carl A.....2966 Kessler Blvd., N. Dr. (22)
Freeman, Leslie W.....I. U. Medical Center (7)
Freeman, Max E.....1745 Howard St. (21)
French, Richard N.....I. U. Medical Center (7)
Fromhold, Willis A....611 Bankers Trust Bldg. (4)
Fry, Robert D.....517 Hume Mansur Bldg. (4)
Funkhouser, Elmer (S) .702 Underwriters Bldg. (4)

G

Gabovitch, Edward R.

Marion Co. General Hospital (7)

Gachaw, Gabra S.

V. A. Hospital, 1481 W. 10th St. (7)

Gaddy, Euclid T.....2602 W. Washington St. (22)
Gaddy, Nelson D....2602 W. Washington St. (22)
Gailey, Ivan.....4895 Knollton Rd. (8)
Gambill, William D.....1633 N. Capitol Ave. (2)
Gammieri, Robert L.....661 E. 49th St. (5)
Garber, J. Neill.....806 Hume Mansur Bldg. (4)
Garceau, George J.....508 Hume Mansur Bldg. (4)
Gard, Daniel A...Ford Motor Co., Box 19106 (19)
Gardiner, Sprague H.....I. U. Medical Center (7)
Gardner, Austin L.....3120 N. Meridian St. (8)
Gardner, Buckman.....St. Vincent's Hospital (7)
Garfield, Martin D.....3705 College Ave. (5)
Garner, W. Stanley.....2704 E. 62nd St. (20)
Garrett, John D. (S).....402 N. Meridian St. (4)
Garrett, Robert A.....I. U. Medical Center (7)
Gatch, Willis D. (S)....605 Hume Mansur Bldg. (4)
Geider, Roy A.....1525 Prospect St. (3)
Geisler, Hans E.....Methodist Hospital (7)
Genna, Mary E. Miller...I. U. Medical Center (7)
Genovese, Pasquale

V. A. Hospital, 1481 W. 10th St. (7)

George, Charles L.....1121 E. 80th St. (20)
Gerig, Eldon L.....Marion Co. General Hospital (7)
Gibson, Alois E.....St. Vincent's Hospital (7)
Gibson, Greta Maxine.5744 Broadway Terrace (20)
Gick, Herman H. (S)....2705 E. Michigan St. (1)
Gifford, Fred E.....710 Hume Mansur Bldg. (4)
Gill, John R.....4638 Graceland Ave. (8)
Gillespie, Charles F.....3400 N. Meridian St. (8)
Gillespie, Jacob E.....523 Hume Mansur Bldg. (4)
Gillim, Parvin D.....I. U. Medical Center (7)

Ginsberg, Stewart T. 1315 W. Tenth St. (7)
Glendening, John L. (S)

7202 N. Meridian St. (20)

Glover, John L. I. U. Medical Center (7)
Godwin, Donald W. Methodist Hospital (7)
Goldenberg, Norman S. Coleman Hospital (7)
Goldman, Samuel 2117 W. Washington St. (21)
Gormley, Joseph J. 2369 Goodlet (23)
Gosman, James H. 2901 N. Meridian St. (8)
Graham, Edward W.

V. A. Hospital, 1481 W. 10th St. (7)

Graham, John D. 1802 N. Illinois St. (2)
Graham, William E. St. Vincent's Hospital (7)
Gray, Kenneth L. Methodist Hospital (7)
Green, Morris Riley Hospital (7)
Greene, Morgan E. 1621 S. East St. (25)
Gregory, Robert L. Methodist Hospital (7)
Greist, John H. 2901 N. Meridian St. (8)
Griffin, Leslie W. Allison Div., General Motors
Griffith, Richard S.

Lilly Clinic, Marion Co. General Hospital (7)

Griffith, Ross E. 401 E. 34th St. (5)

Grimes, Hubert N. 2809 E. Michigan St. (1)

Grisell, Ted L. 5317 East 16th St. (18)

Gruber, Charles M.

Lilly Clinic, Marion Co. General Hospital (7)

H

Habegger, Elmer D. 1802 N. Illinois St. (2)

Hadley, David 702 Hume Mansur Bldg. (4)

Haggard, Edmund B. 5914 N. Emerson Ave. (20)

Hall, Frank M. 100 N. Senate Ave. (4)

Hall, Jack H. Methodist Hospital (7)

Hall, William R. I. U. Medical Center (7)

Hamer, Homer G. (S) 1711 N. Capitol Ave. (7)

Hamilton, Howard B. 764 S. Emerson Ave. (3)

Hammond, James B.

Lilly Clinic, Marion Co. General Hospital (7)

Hampshire, Donald R. 1443 N. Pennsylvania St. (2)

Hancock, John G. 2226 W. Michigan St. (22)

Hanley, Larry L. Methodist Hospital (7)

Hann, Eldon C. 1633 N. Capitol Ave. (2)

Hanna, Thomas A. 1608 N. Lynhurst Dr. (24)

Hannemann, Robert E. I. U. Medical Center (7)

Hansell, Robert M. 6049 E. Washington St. (1)

Harcourt, Allan K. 812 C. of C. Bldg. (4)

Harcourt, Robert S.

Marion Co. General Hospital (7)

Harding, M. Richard 308 Hume Mansur Bldg. (4)

Harding, Myron S. 308 Hume Mansur Bldg. (4)

Hare, Earl H. (S)

Indiana State Board of Health 1330 W.
Michigan St. (7)

Hare, Laura 404 Hume Mansur Bldg. (4)

Harger, Robert W. 804 Hume Mansur Bldg. (4)

Harold, Albert H. (S) 7510 Allisonville Rd. (20)

Harold, Norris E. (S) 3545 N. Denny St. (18)

Harris, Carl B. 319 Hume Mansur Bldg. (4)

Harris, Paul N.

Eli Lilly & Co., 740 S. Alabama St. (6)

Harvey, Verne K., Jr.

Indiana State Board of Health 1330 W.
Michigan (7)

Harvey, Verne K., Sr.

V. A. Hospital, 1481 W. Tenth St. (7)

Haslinger, Clarence J. 2151 E. New York St. (1)

Hatfield, Jack J. 5538 N. Keystone Ave. (20)

Hatfield, Nicholas W. 2032 N. Rural St. (18)

Hawk, James H. 3736 N. Delaware St. (5)

Hawtof, David B. I. U. Medical Center (7)

Hay, Gene R. Marion Co. General Hospital (7)

Haymond, Joseph L. 301 E. 38th St. (5)

Haynes, John T. 2626 W. Washington St. (22)

Hays, Everett L. 2607 Manker Ave. (3)

Healey, Robert J. 3602 N. Meridian St. (8)

Hedrick, Philip W. 652 E. 54th St. (20)

Heimbürger, Robert F. I. U. Medical Center (7)

Heinrichs, Harry H. (S) 2135 N. Alabama St. (2)

Helmen, Charles H. I. U. Medical Center (7)

Henderson, Francis G.

Eli Lilly & Co., 740 S. Alabama St. (6)

Henderson, Roscoe C. 3131 Northwestern Ave. (23)

Henderson, William P.

520 Hume Mansur Bldg. (4)

Hendricks, Fred A. 6921 N. Keystone Ave. (20)

Hendricks, John W. 911 Hume Mansur Bldg. (4)

Henry, Russell S. 725 Hume Mansur Bldg. (4)

Hepburn, C. K. 1633 N. Capitol Ave. (2)

Hetherington, Arthur M. (S)

4121 E. New York St. (1)

Hetherington, John A. 1633 N. Capitol Ave. (2)

Heubi, John E. 668 E. 38th St. (5)

Hickam, John B. I. U. Medical Center (7)

Hickman, Jack W. 625 E. 38th St. (5)

Hickman, Walter F. (S) 1210 Oliver Ave. (21)

Hicks, Murwyn L. 1502 N. Emerson (19)

Hicks, Wilbur P. 310 W. 40th St. (8)

Hill, James K. 4701 W. 30th St. (24)

Himler, James M. 809 Underwriters Bldg. (4)

Hines, Don C.

Eli Lilly & Co., 740 S. Alabama St. (6)

Hodges, Fletcher (S) 3160 N. Penn. St. (5)

Hoffman, Herman 650 E. 38th St. (5)

Hofmann, J. William (S)

323 Hume Mansur Bldg. (4)

Hogan, Michael A. I. U. Medical Center (7)

Holman, Jerome E., Sr. (S) 3315 E. 10th St. (1)

Holman, Jerome E., Jr. 3315 E. 10th St. (1)

Hood, Ainslee A. 3205 Shelby St. (27)

Hooker, Donald J. Methodist Hospital (7)

Horwitz, Thomas 421 Hume Mansur Bldg. (4)

Howell, Arthur 2060 Boulevard Pl. (2)

Howell, Joseph D. 760 Bankers Trust Bldg. (4)

Howell, Robert D. 1802 N. Illinois St. (2)

Hoyt, Charles J. I. U. Medical Center (7)

Hoyt, Lester H. Methodist Hospital (7)

Hoyt, Millard L. 612 Hume Mansur Bldg. (4)

Hubbard, Jesse D. I. U. Medical Center (7)

Huber, Carl P. I. U. Medical Center (7)

Huddle, John R. 2963 N. Sherman Dr. (18)

Hudson, Foster J. 3440 N. Meridian St. (8)

Hull, DeWayne L. I. U. Medical Center (7)

Hull, Ronald H. 723 Hume Mansur Bldg. (4)

Hummons, Francis D. 729½ N. West St. (2)

Hurt, Laverne B. 635 E. Kessler Blvd. (20)

Hurteau, William W. Methodist Hospital (7)

Huse, William M. 703 Hume Mansur Bldg. (4)

Hynes, Roy T. 633 E. 38th St. (5)

I

Irwin, Glenn W., Jr. I. U. Medical Center (7)

Iske, Paul G. 420 Hume Mansur Bldg. (4)

J

Jackson, Frederick E. (S) 2125 N. Park Ave. (2)

Jackson, James W. (S) 463 W. 32nd St. (8)

Jaeger, Alfred S. (S) 3057 Washington Blvd. (5)

Jaquith, Orville S. (S) 261 Blue Ridge Rd. (8)

Jay, Arthur N. 3400 N. Meridian St. (8)

Jay, James M. I. U. Medical Center (7)

Jenkins, Robert E. 3311 N. Meridian St. (8)

Jennings, Frank L. (S)

V. A. Hospital, 1481 W. Tenth St. (7)

Jewett, Joe H. 3120 N. Meridian St. (8)

Jobes, James E. 110 N. Illinois St., #413 (4)

Jobes, Norman E. (S) 4245 Knollton Rd. (8)

Johnson, Earl H. I. U. Medical Center (7)

Johnson, Thomas W. 1802 N. Illinois St. (2)

Johnson, William H. I. U. Medical Center (7)

Jones, Allen W. 6060 College Ave. (20)

Jones, David E. 828 C. of C. Bldg. (4)

Jones, Francis P. 4212 E. Michigan St. (1)

Jones, Gordon C. 1517 N. Emerson (19)

Jones, Lawrence R. 4525 W. 30th St. (24)

Jontz, Richard L. I. U. Medical Center (7)

Joseph, Rex M. 59 E. Troy St. (3)

Jowitt, Richard H. 1502 N. Emerson (19)
 Judd, Donald R. I. U. Medical Center (7)
 Judson, Walter E. I. U. Medical Center (7)

K

Kahler, Maurice V. 2638 Kessler Blvd. (22)
 Kahn, Alexander J. 3120 N. Meridian St. (8)
 Kahn, Howard L. 3120 N. Meridian St. (8)
 Kaiser, George C. I. U. Medical Center (7)
 Kalb, Everett L. 5934 E. 21st St. (18)
 Kammen, Leo. 3202 W. 16th St. (22)
 Kammen, Robert. 3202 W. 16th St. (22)
 Katterjohn, James C. 313 Hume Mansur Bldg. (4)
 Kauffman, Nelson N. 2901 N. Meridian St. (8)
 Keenan, George B. 3225 Shelby St. (27)
 Keenan, Reid L. 615 Hume Mansur Bldg. (4)
 Kever, Charles H. 5214 College Ave. (20)
 Keiser, Venice D. 5709 Broadway (20)
 Kelly, Don E. 702 Underwriters Bldg. (4)
 Kennedy, Hunter F. 1105 Prospect St. (3)
 Kennedy, Joseph T. 1502 N. Emerson (19)
 Kenney, David B. 6032 E. 10th St. (19)
 Kenzler, Jack. 205 Hume Mansur Bldg. (4)
 Kerr, Harry R. 2817 E. Washington St. (1)
 Ketcham, Jane M. (S) 3906 Ruckle St. (5)
 Kime, Edwin N. 4800 E. 42nd St. (18)
 King, Harold. I. U. Medical Center (7)
 King, William E. 811 Hume Mansur Bldg. (4)
 Kingsbury, John K. (S) 5462 E. Washington St. (19)

Kinzel, Robert J. W. 3120 N. Meridian St. (8)
 Kirkhoff, Paul J. 5317 E. 16th St. (18)
 Kirklin, Oren L. 1802 N. Illinois St. (2)
 Kirtley, William R. Eli Lilly & Co., 740 S. Alabama St.

Kissel, Wesley A. Larue Carter Hosp., 1315 W. Tenth St. (7)
 Kitterman, Harry E. 5317 E. 16th St. (18)
 Klain, Benjamin V. 4157 College Ave. (5)
 Klatte, Eugene C. I. U. Medical Center (7)
 Klein, Emanuel. I. U. Medical Center (7)
 Kleopfer, Ronald G. I. U. Medical Center (7)
 Klepinger, Carol A. Methodist Hospital (7)
 Kneidel, John H. 508 E. 38th St. (5)
 Knowles, Charles Y. 5317 E. 16th St. (18)
 Knowles, Robert P. 2901 N. Meridian St. (8)
 Koch, Edwin F., Jr. I. U. Medical Center (7)
 Kohlstaedt, Karl C. Eli Lilly & Co., 740 S. Alabama St. (6)

Kohlstaedt, Kenneth G. Eli Lilly & Co., 740 S. Alabama St. (6)
 Kooiker, John E. 401 E. 34th St. (5)
 Koons, Karl M. 923 Hume Mansur Bldg. (4)
 Kopecky, Robert R. 4131 Shelby St. (27)
 Kornafel, L. H. 608 K. of P. Bldg. (4)
 Kraft, Bennett. 760 Bankers Trust Bldg. (4)
 Kriel, William B. 5630 W. Washington St. (21)
 Kuntz, Herman W. 611 Hume Mansur Bldg. (4)
 Kurlander, Gerald J. I. U. Medical Center (7)
 Kurtz, Fred B. (S) 5520 N. Illinois St. (8)
 Kurtz, Philip L. Eli Lilly & Co., 740 S. Alabama St. (6)

Kwitny, Isadore J. 3400 N. Meridian St. (8)
 Kyle, Michael A. I. U. Medical Center (7)

L

LaDine, Clarence B. 2508 Station St. (18)
 Lalonde, Alban H. 920 Hume Mansur Bldg. (4)
 Lamb, Emmett B. 205 Hume Mansur Bldg. (4)
 Lamb, Russell W. 205 Hume Mansur Bldg. (4)
 Lamber, Chet K. 914 Hume Mansur Bldg. (4)
 Lands, Robert M. Marion Co. General Hospital (7)
 Landwehr, Alfons. Sunnyside Sanitorium (26)
 Lane, Charlotte E. Methodist Hospital (7)
 Lang, Erich K. Methodist Hospital (7)
 Langdon, Harry K. (S) 3264 N. Pennsylvania St. (5)

Lansford, Kenneth G. I. U. Medical Center (7)
 Laramore, Ward V. A. Hospital, 1481 W. 10th St. (7)
 Lasich, Anthony R. 820 C. of C. Bldg. (4)
 Lawler, George F. 3934 E. 10th St. (1)
 Layman, Douglas C. I. U. Medical Center (7)
 Leasure, J. Kent. 3115 N. Meridian St. (8)
 Leatherman, Harter L. 1531 Broadway (2)
 Leffel, James M. 1633 N. Capitol Ave. (2)
 Leffler, William T. 2141 E. 52nd St. (5)
 LeMaster, Theodore R. 305 Hume Mansur Bldg. (4)

Leonard, Henry S. (S) 303 Hume Mansur Bldg. (4)
 Leser, Ralph U. 3233 N. Meridian St. (8)
 Levi, Leon. 40 W. 38th St. (8)
 Levin, Ralph T. 3400 N. Meridian St. (8)
 Lewis, Paul S. 6357 Rockville Rd. (24)
 Lewis, R. Earl. 1638 E. Raymond St. (3)
 Lichtenberg, Melvin. 535 E. 38th St. (5)
 Lidikay, Edward C. 621 Hume Mansur Bldg. (4)
 Lindenborg, Paul G. 3016 N. Arlington Ave. (18)
 Lingeman, Raleigh E. 1944 N. Capitol Ave. (2)
 Lingeman, Roger E. 2081 N. Emerson Ave. (18)
 Link, Goethe (S) 608 K. of P. Bldg. (4)
 Littlefield, Paul A. 4040 Crooked Creek Overlook (8)

Littlefield, Shirley D. 4040 Crooked Creek Overlook (8)

Lloyd, Frank P. 2416 N. Capitol Ave. (8)
 Lochry, Ralph L. 6134 Norwaldo (20)
 Loehr, William M. I. U. Medical Center (7)
 Long, Malcolm D. St. Vincent's Hospital (7)
 Loomis, Norman S. 5230 N. Kenwood Ave. (8)
 Lord, Glenn C. 104 E. 38th St. (5)
 Loudon, Robert W. 8545 Westfield Blvd. (20)
 Loughlin, Lawrence L. 3233 N. Meridian St. (8)
 Love, George N. 5331 Washington Blvd. (20)
 Lozow, David. 3941 Meadows Dr. (5)
 Lucas, Clarence A., Jr. 2012 Boulevard Pl. (2)
 Lukemeyer, George T. I. U. Medical Center (7)
 Lunsford, Thomas E. I. U. Medical Center (7)
 Lurie, Paul R. I. U. Medical Center (7)
 Luros, J. Theodore. 1633 N. Capitol Ave. (2)
 Lybrook, William B. 3731 N. Keystone Ave. (18)

M

MacCollum, M. Speers. St. Vincent's Hospital (7)
 MacDougall, John D. 3941 Meadows Dr. (5)
 McAree, Francis E. Methodist Hospital (7)
 McBride, James S. 810 Hume Mansur Bldg. (4)
 McCallum, Donald C. Methodist Hospital (7)
 McCallum, Joseph T. C. (S) 237 W. 46th St. (8)
 McCartney, Donald H. 918 Hume Mansur Bldg. (4)
 McClain, Edwin S. 414 Hume Mansur Bldg. (4)
 McCormick, Charles O., Jr. 3989 Meadows Dr. (5)

McGrath, Michael F. 1929 E. 38th St. (18)
 McGuff, Paul E. 4829 E. 38th St. (18)
 McIntyre, Charles J. (S) 414 Hume Mansur Bldg. (4)

McIntyre, James M. 2901 N. Meridian St. (8)
 McKinley, A. David. I. U. Medical Center (7)
 McLain, Clarence R., Jr. I. U. Medical Center (7)
 McLaren, Daniel E. 4595 N. Arlington Ave. (26)
 McMillan, Frederick G. (S) 1110 Odd Fellows Bldg. (4)

McQuiston, Ralph J. 608 Guaranty Bldg. (4)
 McTurnan, Robert W. 5646 N. Illinois St. (8)
 Mackey, Harry S. (S) 4309 Central Ave. (5)
 Mackey, John E. 3400 N. Meridian St. (8)
 Madden, Robert J. 4612 E. Tenth St. (1)
 Madtson, A. Ricks. 822 Hume Mansur Bldg. (4)
 Magennis, Herbert L. (S) 520 W. Washington St. (4)

Malcolm, Russell L., Jr. Marion Co. General Hospital (7)
 Manalan, Maurice M. 5831 E. Washington St. (19)
 Manders, Karl L. 3400 N. Meridian (8)

Manhart, Doyle B.
 Marion Co. General Hospital (7)
 Manion, Marlow W.... 601 Hume Mansur Bldg. (4)
 Mann, Mortimer..... 3426 N. Meridian St. (8)
 Mann, Richard E..... 1315 W. Tenth St. (7)
 Manning, K. Randolph. 723 Hume Mansur Bldg. (4)
 Manzie, Michael W..... 1633 N. Capitol Ave. (2)
 Marks, Maurice I..... 2901 N. Meridian St. (8)
 Marsh, Carl M..... 101 N. Shortridge Rd. (19)
 Marsh, Myrle F..... I. U. Medical Center (7)
 Marshall, Albert L., Jr.

Indiana State Board of Health,
 1330 W. Michigan St. (7)

Marshall, Cavins R. (S)..... 43 W. 30th St. (8)
 Martin, Hugh E.

Pitman-Moore Co., 1200 Madison Ave. (6)

Martin, Loren H..... 2626 W. Washington St. (22)
 Martz, Bill L.

Lilly Clinic, Marion Co. General Hospital (7)
 Martz, Carl D..... 912 Hume Mansur Bldg. (4)
 Marvel, Robert J..... 3426 N. Meridian St. (8)
 Masters, John M..... 805 Hume Mansur Bldg. (4)
 Masters, Robert J..... 805 Hume Mansur Bldg. (4)
 Matthew, W. Burleigh. 518 Hume Mansur Bldg. (4)
 Matthews, Bernard J..... 4612 E. 10th St. (1)
 Matthews, William M..... 4612 E. 10th St. (1)
 Maxam, B. T..... 400 Hume Mansur Bldg. (4)
 Mealey, John Jr..... I. U. Medical Center (7)
 Megenhardt, Dennis S..... 1633 N. Capitol Ave. (2)
 Meiks, Lyman T..... Riley Hospital (7)
 Melin, John R..... 3440 N. Meridian St. (8)
 Melloh, Ardis F..... 2821 E. 10th St. (1)
 Mentendiek, Maurice H.

141 Buckingham Dr. (8)

Mericle, Earl W..... 1633 N. Capitol Ave. (2)
 Merrell, Paul 420 Hume Mansur Bldg. (4)
 Mershon, Jack B..... 3508 W. 16th St. (22)
 Mertz, John H. O..... 1711 N. Capitol Ave. (7)
 Michael, Isaac E..... 2966 Kessler Blvd., N. Dr. (20)
 Middleton, Harvey N..... 1823 N. Illinois St. (2)
 Miller, Frank H..... 201 Hume Mansur Bldg. (4)
 Miller, Jerry R..... I. U. Medical Center (7)
 Miller, John D..... Sunnyside Sanitorium (26)
 Miller, John M..... I. U. Medical Center (7)
 Miller, Raleigh S..... 6211 College Ave. (20)
 Miller, Roscoe E..... I. U. Medical Center (7)
 Miofsky, William E..... I. U. Medical Center (7)
 Mitchell, Edward O..... 5704 N. Keystone Ave. (20)
 Mitchell, George H..... 6049 E. Washington St. (19)
 Moenning, John E.

Marion Co. General Hospital (7)

Moenning, Walter P..... 618 K. of P. Bldg. (4)
 Montgomery, William F.

904 Hume Mansur Bldg. (4)

Moore, Donald F.
 Larue Carter Hospital, 1315 W. 10th St. (7)
 Moore, Elwin J..... 6138 N. Hillside (20)
 Moore, Harold T..... 5802 Allisonville Rd. (20)
 Moore, William G.

Marion Co. General Hospital (7)

Morchan, Samuel..... 3769 College Ave. (5)
 Morgan, Margaret E..... 3400 N. Meridian St. (8)
 Moriarty, John R..... 5602 Madison Ave. (3)
 Morrison, Lewis E..... 603 Hume Mansur Bldg. (4)
 Morton, Joseph L..... St. Vincent's Hosp. (7)
 Morton, Walter P..... 3434 Fall Creek Blvd. (5)
 Moser, Rollin H..... 400 Hume Mansur Bldg. (4)
 Moss, Bobby L..... 1121 N. Arlington Ave. (19)
 Moss, Harlan B..... 1849 Nowland (1)
 Moss, Herschel C..... 401 E. 34th St. (5)
 Mothersill, Mark H. (S)..... 3650 College Ave. (5)
 Mouser, Robert W..... 6201 Park Ave. (20)
 Mueller, Lillian B. (S)..... 4026 Broadway (5)
 Mullen, James B..... 3120 N. Meridian St. (8)
 Muller, Lullus P..... 3120 N. Meridian St. (8)
 Muller, Paul F..... 3311 N. Meridian St. (8)
 Muller, Victor H..... St. Vincent's Hosp. (7)
 Mumford, E. Bishop (S)..... 812 C. of C. Bldg. (4)
 Musser, A. Wendell..... I. U. Medical Center (7)

Myers, Charles W. (S).... R. R. 18, Box 256 (24)
 Myers, Roy V..... 1904 N. Rural St. (18)

N

Nagan, Robert F..... 606 Hume Mansur Bldg. (4)
 Nay, Richard M..... 1015 Hume Mansur Bldg. (4)
 Nayyar, Som N..... I. U. Medical Center (7)
 Need, Louis T..... 1927 S. Meridian St. (25)
 Need, Richard L..... I. U. Medical Center (7)
 Nester, Henry G..... 307 City Hall (4)
 Newman, Daniel M..... I. U. Medical Center (7)
 Nicholas, Dennis..... 4456 N. Keystone Ave. (5)
 Nie, Louis W..... 2901 N. Meridian St. (8)
 Nohl, John M..... 975 N. Emerson Ave. (19)
 Nolin, Richard T..... 6007 Michigan Rd. (8)
 Nolting, Henry F. (S)..... 261 W. 40th St. (8)
 Norman, William H..... 908 Hume Mansur Bldg. (4)
 Norris, Howard L..... 704 Hume Mansur Bldg. (4)
 Norris, Max S..... 510 Hume Mansur Bldg. (4)
 Nourse, Myron H..... 1711 N. Capitol Ave. (7)
 Noveroske, Richard J..... I. U. Medical Center (7)
 Nugent, Edwin J..... Allison Div. GMC (6)
 Nurnberger, John L..... I. U. Medical Center (7)

O

O'Brian, Earl J..... 3041 Lafayette Rd. (22)
 Ochsner, Harold C..... 3440 N. Meridian St. (8)
 Offutt, Andrew C..... Indiana State Board of Health,
 1330 W. Michigan St. (7)
 Olvey, Ottis N..... 3769 Park Ave. (5)
 O'Malley, Martha A..... Ind. St. Bd. of Health
 1330 W. Michigan St. (7)

Orders, Clarks E. (S)
 4954 W. 15th St., Speedway (24)

Ormiston, Michael W.
 V. A. Hospital, 1481 W. 10th St. (7)
 Otten, Claude F..... 812 C. of C. Bldg. (4)
 Overley, Ross A..... Larue D. Carter Hospital,
 1315 W. 10th St. (7)

Overley, Toner M., Jr.
 Larue D. Carter Hospital, 1315 W. 10th St. (7)
 Owen, John E..... 605 Hume Mansur Bldg. (4)
 Owens, Tracy C..... 2823 N. Meridian St. (8)

P

Pagedas, Tom C..... Methodist Hospital (7)
 Palmer, Charman F.

Larue D. Carter Hospital, 1315 W. 10th St. (7)
 Palmer, Harley P..... Methodist Hospital (7)
 Palmer, Robert M..... I. U. Medical Center (7)
 Palmer, Robert W..... 3400 N. Meridian (8)
 Pandolfo, Harry..... 234 E. Southern Ave. (25)
 Parker, George F., Jr..... 1502 N. Emerson Ave. (19)
 Parker, John F..... 1706 E. Washington St. (1)
 Parker, Portia..... 2226 W. Michigan St. (22)
 Parks, Herbert E..... 1004 N. Ritter Ave. (19)
 Parmenter, Harry B..... 5940 Nash Lane (24)
 Parr, Robert L..... 3043 E. 38th St. (18)
 Paskind, J..... Marion Co. General Hospital (7)
 Paulin, Burt B..... 812 C. of C. Bldg. (4)
 Paulissen, George T..... 741 Markwood Ave. (27)
 Pearson, John S..... American United Life Ins. Co.,
 30 W. Fall Creek Parkway (6)
 Pearson, Lyman R..... 311 Hume Mansur Bldg. (4)
 Pebworth, Aubrey C. (S)..... 1625 W. Morris St. (21)
 Peck, Franklin B., Jr.

Lilly Clinic, Marion Co. General Hospital (7)
 Peck, Franklin B., Sr.

Eli Lilly & Co., 740 S. Alabama St. (6)
 Peirce, James D.

Eli Lilly & Co., 740 S. Alabama St. (6)
 Pennington, Walter E. (S)

214 Hume Mansur Bldg. (4)
 Perlov, Sylvan H..... 5505 N. Keystone Ave. (20)
 Permer, Erwin..... 136 E. 30th St. (5)
 Peterson, Deward D.

Marion Co. General Hospital (7)
 Petranoff, Theodore V. (S)..... 515 N. Tibbs Ave. (22)

Pettijohn, Fred L. (S).....2460 Central Ave. (5)
 Pfaff, Dudley A.
 V. A. Regional Office, 36 S. Pennsylvania St. (4)
 Phillips, David L.....605 E. 38th St. (5)
 Pickett, Robert D.....400 Hume Mansur Bldg. (4)
 Pierce, Emmett, Jr.
 Marion Co. General Hospital (7)
 Pilcher, Jack E.....1802 N. Illinois St. (2)
 Popplewell, Arvine G.
 Marion Co. General Hospital (7)
 Pribble, Robert H.
 Marion Co. General Hospital (7)
 Price, Francis W.....1002 E. Troy Ave. (3)
 Price, James O.....512 Hume Mansur Bldg. (4)
 Priebe, Fred H.....Marion Co. General Hospital (7)
 Pryor, Richard C.....6111 College Ave. (20)

Q

Quigley, Joseph B.....817 Hume Mansur Bldg. (4)

R

Rabb, Aaron.....Marion Co. General Hospital (7)
 Rabb, Frank M.....915 E. 38th St. (5)
 Rabb, Harry S.....3139 E. 10th St. (1)
 Raber, Robert M.....1633 N. Capitol Ave. (2)
 Rader, George S.....301 Hume Mansur Bldg. (4)
 Rafalski, Thomas A.....3120 N. Meridian St. (8)
 Ragan, William D.....3400 N. Meridian St. (8)
 Ralston, John D.....Central State Hosp. (22)
 Ramsey, Frank B.....1802 N. Illinois St. (2)
 Rapp, George F.....St. Vincent's Hosp. (7)
 Rawls, George H.....1540 Columbia Ave. (2)
 Reed, Philip B.....4131 N. Meridian St. (8)
 Rees, Russel C.....6114 E. Washington St. (19)
 Reid, Charles A.....2445 Shelby St. (3)
 Reisler, Simon (S).....318 Bankers Trust Bldg. (4)
 Reuter, John W.....I. U. Medical Center (7)
 Rhamy, Robert K.....I. U. Medical Center (7)
 Rice, Frederic A.....7017 Pendleton Pike (26)
 Rice, Raymond M.
 Eli Lilly & Co., 740 S. Alabama St. (6)
 Richardson, Thad T.....513 S. Sherman Dr. (3)
 Richter, Arthur B.....720 Hume Mansur Bldg. (4)
 Ridgeway, Ora W. (S).....411 E. 16th St. (2)
 Ridolfo, Anthony S.
 Eli Lilly & Co., 740 S. Alabama (6)
 Riner, Jack K.....Methodist Hospital (7)
 Ritchey, James O.....608 Hume Mansur Bldg. (4)
 Ritter, Wayne L.....404 Hume Mansur Bldg. (4)
 Robb, John A.....238 Hume Mansur Bldg. (4)
 Robertson, Ray B.....6118 E. Washington St. (19)
 Rochlin, Isidore.....3202 N. Meridian St. (8)
 Roesch, Ryland P.....I. U. Medical Center (7)
 Roeske, Nancy A.....220 W. Beverly Dr. (5)
 Rogers, Donald L.....3426 N. Meridian St. (8)
 Rogers, Thomas P.....210 N. Warman Ave. (22)
 Rohn, Robert J.....I. U. Medical Center (7)
 Roll, John W.....3628 N. Sherman Dr. (18)
 Roller, Charles W. (S).....915 Hervey (3)
 Romberger, Floyd T., Jr. 3440 N. Meridian St. (8)
 Rosenak, Bernard D.....226 Hume Mansur Bldg. (4)
 Rosenbaum, Irving, Jr.....401 E. 34th St. (5)
 Ross, Alexander T.....I. U. Medical Center (7)
 Roth, Bertram S.....6358 College Ave. (20)
 Row, D. Hamilton.....906 Hume Mansur Bldg. (4)
 Ruddell, Karl R. (S).....3202 N. Meridian St. (8)
 Ruddell, Keith R.....3202 N. Meridian St. (8)
 Rudesill, Cecil L. (S) 405 Hume Mansur Bldg. (4)
 Rudesill, Robert L.....405 Hume Mansur Bldg. (4)
 Rudolph, Kenneth J.....1827 N. Norfolk (24)
 Russell, John R.....315 Hume Mansur Bldg. (4)
 Rust, Byron K.....3740 Central Ave. (5)
 Rust, Roland B.....3939 Meadows Drive (5)
 Ruth, Martin L.....4304 E. Washington St. (1)
 Rutherford, Cyrus W. (S)
 4601 N. Pennsylvania St. (5)
 Ryan, Glen V.....2428 W. 16th St. (22)

S

Sage, Russell A.....1944 N. Capitol Ave. (2)
 Salb, Max C.....826 C. of C. Bldg. (4)
 Samter, Thomas G.....I. U. Medical Center (7)
 Sanders, Harry M.....4829 E. 38th St. (18)
 Schaffer, Edward V... 806 Hume Mansur Bldg. (4)
 Schechter, John S.....3400 N. Meridian St. (8)
 Scheeringa, Ronald H.....Methodist Hospital (7)
 Scheier, Emil W.....9220 Vandergriff Rd. (19)
 Schlaegel, Theodore F., Jr.
 419 Hume Mansur Bldg. (4)
 Schlegel, Donald M.....1802 N. Illinois St. (2)
 Schmalhausen, Ansel W.....Methodist Hospital (7)
 Schmidt, Loren F.....605 Hume Mansur Bldg. (4)
 Schmoyer, Maurice R... Community Hospital (19)
 Schneider, Carl J.....1008 N. Beville Ave. (1)
 Schnute, Richard B.....I. U. Medical Center (7)
 Schuchman, Abe.....3763 Broadway (5)
 Schuchman, Gabriel.....3451 College Ave. (5)
 Schuster, Dwight W... 723 Hume Mansur Bldg. (4)
 Schwarz, Anton
 Pitman-Moore Co., 1200 Madison Ave. (6)
 Scofield, John B.....3120 N. Meridian St. (8)
 Scott, George E.....4110 Roland Rd. (8)
 Scott, I. Winfield.....3400 N. Meridian St. (8)
 Scott, John R.....6214 Broadway (20)
 Scott, Robert P.....209 Hume Mansur Bldg. (4)
 Scott, Samuel L.....6325 Guilford Ave. (20)
 Seaman, Charles F... 301 Hume Mansur Bldg. (4)
 Sedam, Herbert L.....4548 College Ave. (5)
 Segar, Louis H. (S).....818 E. 48th St. (5)
 Segar, William E.....Riley Hosp. (7)
 Sellmer, George W.....8545 Westfield Blvd. (20)
 Sexson, Hiram T.....3731 N. Keystone (18)
 Shafer, Marion R.....614 Hume Mansur Bldg. (4)
 Shanafelt, Donald K.....1802 N. Illinois St. (2)
 Shapiro, Burton J.....3440 N. Meridian St. (8)
 Sheehan, Francis G... 6049 E. Washington St. (19)
 Shelley, Richard J.....6016 E. Washington (19)
 Sherster, Harry.....1135 S. Meridian St. (25)
 Shipley, Edward
 Larue Carter Hospital, 1315 W. Tenth St. (7)
 Shullenberger, Wendell A... 3740 Central Ave. (5)
 Shumacker, Harris B., Jr. I. U. Medical Center (7)
 Sicks, Okla W.....606 Hume Mansur Bldg. (4)
 Sidebottom, Earl W... 507 Hume Mansur Bldg. (4)
 Siderys, Harry.....3941 Meadows Dr. (5)
 Siebe, Jack C.....4829 E. 38th St. (18)
 Siersdorfer, Theodore N. (S)
 5559 W. Morris St. (21)
 Sigmond, Harvey W... 321 Hume Mansur Bldg. (4)
 Silver, Richard A.....712 Hume Mansur Bldg. (4)
 Simmons, James E.....I. U. Medical Center (7)
 Simms, J. Leon.....2453 Northwestern Ave. (23)
 Simpson, William D... 6049 E. Washington St. (19)
 Sims, J. Lawrence.....3400 N. Meridian St. (8)
 Sisk, Phillip B.....I. U. Medical Center (7)
 Sluss, David H.....808 C. of C. Bldg. (4)
 Sluss, John W. (S).....808 C. of C. Bldg. (4)
 Smith, David L.....2901 N. Meridian St. (8)
 Smith, Edward B.....I. U. Medical Center (7)
 Smith, E. Rogers.....822 Hume Mansur Bldg. (4)
 Smith, Francis C.....983 N. Arlington Ave. (19)
 Smith, Roy Lee.....707 Underwriters Bldg. (4)
 Smith, William B... 2229 Northwestern Ave. (23)
 Snider, Byron.....2717 S. East St. (3)
 Solomon, Reuben A... 414 Hume Mansur Bldg. (4)
 Soper, Hunter A.....1015 Hume Mansur Bldg. (4)
 Souter, Martha C.....3360 N. Meridian St. (8)
 Southworth, John W.....1315 W. Tenth St. (7)
 Sovine, Joe W.....922 Hume Mansur Bldg. (4)
 Spahr, John F., Jr. 3440 N. Meridian St. (8)
 Spalding, Joseph J... 706 Hume Mansur Bldg. (4)
 Sparks, Alan L.....1024 Hume Mansur Bldg. (4)
 Spears, John M.....5562 Madison Ave. (27)
 Speckman, Glenn H... 2120 E. 10th St. (1)
 Spivey, Russell J... 2616 N. Pennsylvania St. (5)

Spolyar, Louis W. Indiana State Board of Health,
1330 W. Michigan St. (7)
Spath, Carl B., Jr. 301 Doctors' Bldg. (4)
Stach, Thomas W. I. U. Medical Center (7)
Stadler, Harold E. 5508 E. Washington St. (19)
Stander, Richard W. I. U. Medical Center (7)
Stansbury, William E. 3628 N. Sherman Dr. (18)
Staten, Jesse C. Chevrolet Body Div., GMC,
340 White River Pkwy., W. Dr. S. (22)
Stayton, Chester A., Jr. 313 Hume Mansur Bldg. (4)

Steinmetz, Edward F. Marion Co. General Hospital (7)
Stephens, Donald E. 6332 Guilford Ave. (20)
Stephens, Kuhrman H. 501 Hume Mansur Bldg. (4)
Stevens, Sydney L. 303 Hume Mansur Bldg. (4)
Stewart, L. Ray I. U. Medical Center (7)
Stoelting, Vergil K. I. U. Medical Center (7)
Stone, Alvin T. 6202 College Ave. (20)
Storey, D. Edmund 6225 Broadway (20)
Storey, Joseph L. 3454 N. Illinois St. (8)
Storms, Roy B. (S) 812 C. of C. Bldg. (4)
Strang, William C. Larue D. Carter Hosp.,
1315 W. 10th St. (7)
Streeter, Ralph T. 3131 E. 38th St. (18)
Strickland, Neil R. 1436 E. 46th St. (5)
Stroup, Tyler J. 216 K. of P. Bldg. (4)
Stucky, Elsworth K. 1349 Madison Ave. (25)
Stump, Loyd K. 3941 Meadows Dr. (5)
Stump, Thomas A.

Marion Co. General Hospital (7)
Suelzer, John G. I. U. Medical Center (7)
Summerlin, Jack D. I. U. Medical Center (7)
Sutnick, Alton I. Marion Co. General Hospital (7)
Sutton, William E. 521 Hume Mansur Bldg. (4)
Swan, John R. 915 Hume Mansur Bldg. (4)
Sweeney, Robert M. Methodist Hospital (7)
Symmes, Alfred T. 625 E. 38th St. (8)
Szygal, John S. 633 E. 38th St. (5)

T

Takahashi, Masato Marion Co. General Hospital (7)
Talbot, Dan E. 1802 N. Illinois St. (2)
Tanner, Henry S. 321 Hume Mansur Bldg. (4)
Taube, Jack I. 1007 Hume Mansur Bldg. (4)
Taylor, Clifford C. Community Hospital (19)
Taylor, Cyril I. U. Medical Center (7)
Taylor, Frederic W. 822 Hume Mansur Bldg. (4)
Teague, Frank W. 918 Hume Mansur Bldg. (4)
Teixler, Victor A. 224 Hume Mansur Bldg. (4)
Tepfer, Milton Marion Co. General Hospital (7)
Test, Charles E. 1002 Hume Mansur Bldg. (4)
Teter, George V. 401 E. 34th St. (5)
Tether, Joseph E. 510 Hume Mansur Bldg. (4)
Tharpe, Ray G. 3202 N. Meridian St. (8)
Thatcher, Hugh K., Jr. 4548 College Ave. (5)
Thomas, Charles R. Methodist Hosp. (7)
Thomas, Edward P. 917 W. 30th St. (23)
Thomas, Fred A. St. Vincent's Hospital (7)
Thomas, Lowell I. 615 Hume Mansur Bldg. (4)
Thomas, Morris E. 1802 N. Illinois St. (2)
Thompson, John V. 7899 Ridge Rd. (20)
Thompson, Joseph F. 2901 N. Meridian St. (8)
Thompson, Paul D. 423 Hume Mansur Bldg. (4)
Thompson, Wayne H. 5317 E. 16th St. (18)
Thornburg, Kenneth E. 1633 N. Capitol Ave. (2)
Thornton, Harold C. 301 E. 38th St. (5)
Throop, Frank B. 3400 N. Meridian St. (8)
Tindall, George T. 6002 Windsor Dr. (18)
Tinsley, Frank W. 3044 LaFayette Rd. (22)
Tinsley, Walter B., Jr. 3044 LaFayette Rd. (22)
Tinsley, Walter B. (S) 603 K. of P. Bldg. (4)
Tischer, E. Paul 208 Hume Mansur Bldg. (4)
Tondra, John M. 408 Hume Mansur Bldg. (4)
Torrella, Jose A. 5324 W. 16th St. (24)
Tosick, William A.

Marion Co. General Hospital (7)
Toumey, Fred L. 1802 N. Illinois St. (2)

Trusler, Harold M. 408 Hume Mansur Bldg. (4)
Tschetter, David J. 3202 N. Meridian St. (8)
Tuchman, Joseph H. 2040 E. 46th St. (5)
Tucker, Warren S. 414 Hume Mansur Bldg. (4)
Tyler, Edward A. I. U. Medical Center (7)
Tyner, Harlan H. 3202 N. Meridian St. (8)

U-V

Ullom, Ralph B. Methodist Hospital (7)
Vandivier, Robert M. 209 Hume Mansur Bldg. (4)
Van Dorn, Myron J. 2165 Weslynn Dr. (8)
Van Fleet, Josephine Indiana State Board of
Health, 1330 W. Michigan St. (7)
Van Meter, C. Powell 3419 E. 10th St. (1)
Van Nuys, John D. I. U. Medical Center (7)
Van Tassel, Charles J. 709 Hume Mansur Bldg. (4)
Van Vactor, Helen D. 226 Hume Mansur Bldg. (4)
Vellios, Frank I. U. Medical Center (7)
Vollrath, Victor J. 5202 N. Illinois St. (8)
Von Der Haar, Gerard 4016 E. Michigan St. (1)
Vore, Robert E. Marion Co. General Hospital (7)
Voyles, Charles F. (S) 4150 N. Meridian St. (8)

W

Wagner, Anabel R. I. U. Medical Center (7)
Wagner, Lindley H. I. U. Medical Center (7)
Wainscott, Clinton S. Marion Co. General Hospital (7)
Waldo, J. Thayer 610 Hume Mansur Bldg. (4)
Walker, Robert K. 40 E. 54th St. (20)
Walther, Joseph E. 3202 N. Meridian St. (8)
Walton, William M. 1802 N. Illinois St. (2)
Ward, Wesley C. 3 E. 46th St. (5)
Warman, Alvah P. (S) 1363 E. 38th St. (5)
Warneke, Charles H. St. Vincent's Hospital (7)
Warriner, James B. 1012 N. Emerson Ave. (19)
Warvel, John H., Jr. 4312 Swanson Dr. (8)
Warvel, John H. 614 Hume Mansur Bldg. (4)
Webster, Paul L. I. U. Medical Center (7)
Wehrman, Jule O. (S) 1408 N. Pennsylvania St. (2)

Weigand, Clayton G. Eli Lilly & Co.,
740 S. Alabama St. (26)
Weiss, Jason 4914 W. 16th St. (24)
Weller, Charles A. (S) 3720 N. Delaware St. (5)
West, Joseph L. 6714 Rockville Rd. (41)
Westfall, B. Kemper 2901 E. 38th St. (18)
Westfall, John B. 1025 Hume Mansur Bldg. (4)
Wheeler, David E. Community Hospital (19)
White, Donald J. 502 Bankers Trust Bldg. (4)
White, Douglas H. 1015 Hume Mansur Bldg. (4)
White, John B. 806 Hume Mansur Bldg. (4)
White, Nicholas I. U. Medical Center (7)
White, Philip T. I. U. Medical Center (7)
Wickstrom, Otto W. 3440 N. Meridian St. (8)
Widdifield, G. E. 2614 Madison Ave. (3)
Wilkins, Irvin W. 1743 Shelby St. (3)
Williams, Charles D. 2422 Station St. (1)
Williams, Clifford L. Central State Hospital (22)
Williams, Harold W. 5839 E. Washington St. (19)
Williams, Howard S. 115 E. 16th St. (2)
Williams, Hugh L. 4829 E. 38th St. (18)
Williams, Paul D. Central State Hospital (22)
Wilmore, Ralph C.

V. A. Hospital, 1481 W. 10th St. (7)
Wilson, Fred M. I. U. Medical Center (7)
Wilson, Ned A. I. U. Medical Center (7)
Wilson, Oliver R. 3440 N. Meridian St. (8)
Wirey, Harold R. 6850 S. Madison Ave. (27)
Wise, William R. 120 E. 22nd St. (2)
Wishard, William N., Jr. 1711 N. Capitol Ave. (7)
Witham, Robert L. 1502 N. Emerson (19)
Wohlfeld, Gerald M. 440 N. Winona St., #219 (2)
Wolfram, Don J. 208 Hume Mansur Bldg. (4)
Wood, Donald E. 6325 Guilford Ave. (20)
Woodard, Abram S. 668 E. 38th St. (5)
Woolling, Kenneth R. 718 Hume Mansur Bldg. (4)
Worley, Joseph P. 5839 E. Washington St. (19)

Worley, Richard H.....5317 E. 16th St. (18)
 Wrege, Malcolm L.....1502 N. Emerson Ave. (19)
 Wright, J. William, Jr. 301 Hume Mansur Bldg. (4)
 Wytttenbach, John E....503 Hume Mansur Bldg. (4)

Y

Yacko, Michael L.....1502 N. Emerson (19)
 Young, James W.....6302 Guilford Ave. (20)
 Young, John E.....4829 E. 38th St. (18)
 Young, John M.....1456 E. 46th St. (5)
 Young, John T.....1540 Columbia Ave. (2)

Z

Zell, Evertson H.....812 C. of C. Bldg. (4)
 Zerfas, Phyllis K.....R. R. 1, Box 220 (27)
 Zore, Joseph J.....I. U. Medical Center (7)

Lewis, Robert J.....Lawrence
 Asher, Ernest O. (S).....New Augusta
 Asher, James W.....New Augusta
 Thrasher, John R. (S)
 R. R. 1, Box 362, New Augusta
 Freeborn, Warren S.....Oaklandon
 Miller, Joseph A.....Oaklandon
 Paynter, Morris B.....Southport
 Jones, George L.....Wanamaker

Adams, Daniel S. (S)
 2532 Columbus Dr., Ft. Myers, Fla.
 Bobowski, Stan J.....Letterman Army Hosp.,
 San Francisco, California
 Bohner, Caryle B.....Huasca, Hidalgo, Mexico
 Brayton, John R., Jr.
 1616 George St., Key West, Florida
 Breneman, William L.
 3415 USAF Hosp., Lowry AFB, Denver, Colo.
 Bugh, Charles W.
 1075 Riverview Dr., Fairbanks, Alaska
 Burman, Leonard
 9509 Glasgow Pl., Los Angeles 45, California
 Burton, Philip B.
 230 N. Daugherty, Ft. Bragg, N. C.
 Call, William H.
 University Hospital, Ann Arbor, Michigan
 Childress, Robert C.
 3916 W. University, Gainesville, Fla.
 Close, Gerald A.
 The Towers, S. Darenth, Kent, England
 Coade, George E.
 U. S. Naval Disp., Long Beach, Calif.
 Cullen, Paul K., Jr.
 Mayo Clinic, Rochester, Minnesota
 Dailey, James E....525 E. Grant St., Watseka, Ill.
 Dickey, William M.
 V. A. Hospital, Bay Pines, Florida
 Dierdorf, Fred W....Ind 7520th U. S. A. F. Hosp.,
 APO 125, New York, N. Y.
 Dirks, Kenneth R.....10th Med. Lab., Landstuhl
 Army Med. Center, APO 180, N. Y., N. Y.
 Dixon, Fritz R.
 1034 Irvin St., Winston-Salem, N. C.
 Fisher, Gerald.....Ippy, French Equatorial Africa
 Fosgate, Harold L.
 4626 Pacific Coast Hgwy., Torrance, Calif.
 Fulton, William H.
 358 Sharon Amity Rd., Charlotte, N. C.
 Gabe, William E.
 61 Heather Lane, Orinda, California
 Grayson, Ted L....Barnes Hospital, St. Louis, Mo.
 Harshman, James A.
 U. S. Naval Hosp., Great Lakes, Ill.
 Huffman, Galen C.
 Columbus Psy. Inst. and Hosp., Columbus 10, Ohio
 Irick, Robert L.
 48th TAC Hospital, APO 179, New York, N. Y.

Jones, Roland W.
 USN Hospital, Bethesda, Maryland
 Kenoyer, Wilbur L....Keesler AFB, Biloxi, Miss.
 Kilgore, Byron W.
 3322 Westwood Dr., Topeka, Kan.
 Kurtz, Richard..2901 S. Parkway, Chicago, Illinois
 Lambert, Ross W.
 USN Hospital, Camp Pendleton, California
 Little, John W. (S)
 221 S. Moreland Place, Decatur, Ill.
 McCallum, Robert M.
 R. R. 3, Arcadia Lake, Columbia, S. C.
 Mertz, Henry O., Sr. (S)
 R. R. 2, Box 1619, Nokomis, Florida
 Moore, Richard B.
 931 St. Paul Ave., #9, St. Paul, Minn.
 Morrow, Dean H.
 Nat'l. Institutes of Health, Bethesda, Maryland
 Murray James S.
 980 Mission Terrace, Camarillo, Calif.
 Neely, Alonzo S. (S)
 213 N. Kenton St., Urbana, Ohio
 Nelson, Audrey H.
 1719 Macaulay, Memphis, Tennessee
 Nelson, John W.
 1719 Macaulay, Memphis, Tennessee
 Norris, Mary Alice,
 c/o Col. J. F. Surratt, Quarters 3,
 Ft. Sheridan, Illinois
 Parker, L. Burton..837 Baltimore Dr., Orlando, Fla.
 Powell, Richard C.
 USA Med. Res. Nut. Lab., Fitzsimmons Hospital,
 Denver, Colorado
 Reibel, Donald B.
 Hosp. for Special Surgery, New York 21, N. Y.
 Rhodes, Theodore D.
 R. R. #2, Box 1595, Nokomis, Fla.
 Rice, Reed...720 16th Ave. N.E., Rochester, Minn.
 Ricketts, Joseph W. (S)
 136 Magnolia Drive, Orman Beach, Florida
 Rigg, John F.
 1279 N. E. 97th Street, Miami Shores, Florida
 Robinson, Frank C. (S)
 200 Via Mentone, Newport Beach, Calif.
 Rohrbacker, Donald M.
 V. A. Hospital, Portland, Oregon
 Rudolph, Stephen J., Jr.
 832nd TAC Hosp., Cannon AFB,
 New Mexico
 Rupel, Ernest
 1841 Venetian Pt. Dr., Clearwater, Florida
 Shoptaugh, A. Glenn Jr.
 30750th USAF, Sheppard AFB
 Wichita Falls, Texas
 Slichenmyer, Jack E.
 Westover AFB, Chicopee Falls, Mass.
 Sommers, Stephen D.
 USAF Hosp., Wright-Patterson AFB,
 Dayton, Ohio
 Sprenger, Thomas R.
 25 Davis Blvd., Tampa 6, Fla.
 Stanley, John S....470 N. E. 25th St., Miami 37, Fla.
 Steury, Ernest M.
 Kenya Colony, British East Africa
 Szumilas, Peter P.
 F. E. Warren AFB, Cheyenne, Wyo.
 Talarico, Leonard H.
 219 Orlando Rd., Rochester 22, N. Y.
 Taylor, Max T.
 Martin Army Hospital, Fort Benning, Ga.
 Thurston, Harrison S. (S)
 1204 Earham Drive, Dayton 6, Ohio
 Tinney, William E. (S)
 P. O. Box 1186, Pass-A-Grille, Florida
 Wallace, Collins R.
 Ireland Army Hosp., Ft. Knox, Ky.
 Willitts, Bruce K.
 U. S. Naval Dispensary, Norfolk, Va.

Yingling, Robert J.
U. S. Naval Hospital, Key West, Fla.
Ziperman, H. Haskell
Box 108, Letterman Army Hosp.,
San Francisco, Calif.

MARSHALL COUNTY

Hampton, James N.....Argos
Kelly, Frank (S).....Argos
Connell, Vactor O.....Bourbon
Marshall, George L. (S).....Bourbon

Bremen

Bowen, Otis R.....424 W. South St.
Burket, Cecil R.....424 W. South St.
Cripe, Earl P.....119 N. Center St.
Schreiner, John E.....201 E. Plymouth
Stine, Marshall E.....424 W. South St.

Baker, Milan D.....Culver
Norris, Ernest B.....Culver
Reed, Donald.....Culver

Plymouth

Connell, Paul S.....320 N. Center St.
Coursey, James O.....109 N. Walnut St.
France, Lloyd C.....1223 N. Center St.
Kubley, James D.....304 N. Walnut St.
Peterson, Ronald L.....121 E. Garro St.
Rimel, James F.....1223 N. Center St.
Robertson, James S.....304 N. Walnut St.
Vore, Louring W.....121 E. Garro St.

Thompson, Alfred A. (S).....Tyner

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Malott, Fred R.....Converse
Sennett, William K.....Macy
Rendel, Harold E.....Mexico

Peru

Barnett, Ralph E.....65 N. Miami St.
Boone, Max L.....65 N. Miami St.
Carlson, Edward A. (S).....11½ W. Main St.
Ferrara, Donald W.....18 W. Fifth St.
Ferrara, Samuel J.....18 W. Fifth St.
Guthrie, James U.....331 W. Third St.
Herd, Cloyd R.....15 S. Wabash
Hill, Lloyd L.....65 N. Miami St.
Malouf, Stephen D. (S).....53 S. Broadway
Snyder, Parker M.....65 N. Miami St.

Kimmel, George E.
U. S. Naval Hospital, Camp Lejeune, N. C.
Tan, Constancio C.
Mary Immaculate Hosp., Newport News, Va.

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY**Crawfordsville**

Alexander, Stephen J.....306 Ben-Hur Bldg.
Burks, Jess E.....411 Ben Hur Bldg.
Cornell, Robert A.....219 Ben Hur Bldg.
Daugherty, Fred N.....120 W. Pike St.
Dodds, Wemple.....Culver Hospital
Eggers, Richard.....120 W. Pike St.
Fisher, Frank L.....R. R. Donnelley & Sons Co.
Haller, Thomas C.....411 Tinsley Ave.
Humphreys, John W.....312 Jones Ave.
Kinnaman, Howard A.....206 Ben Hur Bldg.
Kirtley, James M.....416 Ben Hur Bldg.
Lingeman, Byron N.....419 Ben Hur Bldg.
Millis, Samuel C.....416 Ben Hur Bldg.
Peacock, Norman F.....219 Ben Hur Bldg.
Pierson, Robert H.....305 E. Main St.
Shannon, Wesley E.....901 Cottage Ave.
Wallace, Hawthorne C.....411 Tinsley Ave.

Otten, Ralph E.....Darlington
Blix, Fred M.....Ladoga
Wong, Norman F.....Linden
Davis, William H.....New Market
Kindell, Hurschell D.....New Richmond
Thompson, Claude N.....Waynetown
Parker, Carl B.....Wingate

Cooksey, Thomas L. (S)
320 N. Mission St., Santa Barbara, Calif.

MORGAN COUNTY**Martinsville**

Eisenberg, David A.....310 N. Main St.
Gibbs, Joseph W.....Home Lawn Sanitarium
Gray, Leon.....171 E. Washington St.
Johnston, Alan.....R. R. #6
Miller, Ray D.....290 E. Washington St.
Van Wienen, John.....60 W. Morgan
Wilkinson, Dudley E.....171 E. Washington St.
Winter, William P.....1390 E. Columbus

Murphy, Maurice G. (S).....Morgantown

Mooresville

Bivin, James H.....31 S. Indiana
Karpel, Bernard.....Medical Arts Bldg.
Van Bokkelen, Robert W.....320 N. Indiana

Farr, James C.....Paragon

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M.....Albion
Nash, Justin R.....Albion
Mattniller, Everette D.....Avilla
Sneary, Kenneth D.....Avilla
Sneary, Max E.....Avilla

Kendallville

Bryan, Robert E. 705 N. State St.
 Carey, Willis W. (S) Lutheran Home
 Gutstein, Richard R. (S) 120 Diamond
 Hepner, Herman 705 N. State St.
 Lawson, Isaac H. (S) 125½ S. Main St.
 Messer, Frank W. 115 E. Rush St.
 Slough, O. Thomas 112 W. Mitchell
 Stallman, Carl F. 409 E. Wayne St.

Ligonier

Chase, James A. 104 S. Main St.
 Stone, Robert C. 401 S. Main St.
 Stultz, Quentin F. 401 S. Cavin St.

Fipp, August L. Rome City
 Pulskamp, Bertrand H. Wolcottville
 Luckey, Robert C. Wolf Lake
 Roth, James R. Wolf Lake

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, N. E. French Lick Springs
 Sugarman, Benjamin E. French Lick Springs
 Hodgins, Philip T. Orleans
 Schoolfield, William E. Orleans
 Clark, Ivan A. Paoli
 Manship, Stanley Paoli
 McCalla, Charles X. Paoli
 Spears, John K. Paoli
 Miller, Henderson L. (S) West Baden Springs

OWEN-MONROE COUNTIES**Bloomington**

Baxter, Neal E. 306 E. Fifth St.
 Bidney, Evelyn B. 321 S. Jordan Ave.
 Borland, Raymond M. R. R. 3
 Buckingham, Richard E. 344 College Ave.
 Cochran, John F. Indiana University
 Creek, Jean A. 312 N. Walnut St.
 Estes, Ambrose C. 121 E. Kirkwood Ave.
 Fowler, Richard R. 104 N. Grant St.
 Geiger, Dillon D. 300 E. Kirkwood
 Hardtke, Eldred F. 509 E. Fourth St.
 Hepner, Herman S. 312 N. Walnut St.
 Hibner, Kermit Q. 117 N. Grant St.
 Holland, Deward J. (S) 313 N. College Ave.
 Holland, Philip T. 108 W. 7th St.
 Holtzman, Paul W. 615 N. College
 Hrisomalos, Frank N. 306 E. Fifth St.
 Karsell, William A. 306 E. Kirkwood
 Link, William C. 110 E. Fourth St.
 Lundblad, Wilfred M. 1805 E. Tenth St.
 Lyons, Robert E. 321 E. Kirkwood
 Manifold, Harold M. 114 N. Lincoln St.
 Marchant, Clarence H. 350 S. College Ave.
 McIntire, Clarence B. Bloomington Hospital
 Middleton, Thomas O. 404 E. Seventh St.
 Milan, Joseph F. 106 N. Grant St.
 Miller, John M. Indiana University
 Pizzo, Anthony Bloomington Hospital
 Poolitsan, George C. 407 N. Walnut St.
 Quarles, E. Bryan Indiana University
 Ramsey, Hugh S. 307 E. Kirkwood
 Reed, William C. 307 E. Kirkwood
 Rieger, I. Taylor 102 N. Grant St.
 Rogers, Otto F., Jr. 210 N. Washington St.

Rollins, Thomas K. 114 E. Seventh St.
 Ross, Ben R. 314 E. Seventh St.
 Ross, James B. 314 E. Seventh St.
 Schuman, Edith B. Indiana University
 Sibbitt, Joseph W. 300 E. Kirkwood
 Smith, Herschel S. 110 S. Lincoln
 Smith, Rodney D. (S) 115 N. Washington St.
 Spencer, Beaufort A. 114 N. Lincoln
 Stangle, William J. 640 S. Rogers
 Taraba, Ralph W. Indiana University
 Topoligus, James N. 403 N. Walnut St.
 Wenzler, Paul J. 110 S. Washington St.
 Wilson, Talmage L. 301 E. Kirkwood

Stouder, Charles E. Ellettsville
 Mitchell, George L. (S) Smithville
 Brown, Marcel S. Spencer
 Kay, Oran E. Spencer
 Smith, Frederick R. Spencer

PARKE-VERMILLION COUNTIES

Greene, Frederick G. (S) Bloomingdale
 Goodrum, William R. Cayuga

Clinton

Evans, Frederick J. 242 S. Third St.
 Gerrish, Wakefield D. (S) 125 S. Fifth St.
 Herzberg, Milton 222 Elm St.
 Kercheval, John M. 819 S. Third St.
 White, Isaac D. (S) 427 S. Fourth St.

Lauer, Dorothy B. Dana
 Britton, Welbon D. Montezuma
 De Renne, William L. Newport
 Johnson, William A. (S) Perrysville

Rockville

Bloomer, Richard S. 115 N. Market St.
 Dowell, Emil H. Parke Hotel Bldg.
 Harstad, Casper 216 W. High St.
 Kempf, Gerald F. Indiana State Sanitarium
 Merrell, Basil M. 110 E. York St.
 Noblitt, James S. (S) Rockville
 Pace, Jerome V. Indiana State Sanitarium
 Pirkle, Hubert B. Indiana State Sanitarium
 Zierer, Reuben O. Indiana State Sanitarium
 Fell, Robert M. Rosedale
 White, Chester S. (S) Rosedale

PERRY COUNTY

Bush, Hargis R. Cannelton

Tell City

Dome, Hardin S. (S) 704 Ninth St.
 Dukes, David A. 521 Main St.
 Gilbert, Robert G. Perry Co. Mem. Hosp.
 Glenn, Fred C. (S) 436 Main St.
 Herr, John W. 622 Main St.
 James, John M. 746 Ninth St.
 James, Nicholas A. (S) 746 Ninth St.
 Kemker, Bernard P. 746 Ninth St.
 Lohoff, Lewis C. 507 Main St.
 Neifert, Noel L. 507 Main St.
 Smith, Fred, Jr. 507 Main St.

Snyder, Earl R. (S) Troy

PIKE COUNTY**Petersburg**

Hall, Donald L.....7th & Poplar Sts.
Omstead, Milton.....110 S. Sixth St.

DeTar, George B. (S).....Winslow

Higgins, James L.
MAAG APO 63, San Francisco, Calif.

PORTER COUNTY**Chesterton**

Griffin, Joseph P.....Jackson Blvd.
Hall, Thomas C.....621 Broadway
Harless, Clarence M.....123 Indiana Ave.
Read, John E.....114 S. 11th St.
Robertson, William C.....600 E. Morgan

Cohen, Hyman.....Hebron
Kleinman, Francis J. (S).....Hebron

Valparaiso

Brown, James C.....101 Lincolnway
Covey, Thomas J.....552 Lincolnway
Davis, Carl M.....202 Indiana Ave.
DeGrazia, Eugene J.....810 LaPorte Ave.
Dittmer, Jack E.....23 Lincolnway
Dittmer, Thomas L.....23 Lincolnway
Eades, Ralph C.....6 Napoleon St.
Frank, John R. (S).....23 Lincolnway
Green, Leonard J.....8 N. Garfield
Griffin, Charles G.....813 La Porte Ave.
Koenig, Robert L.....810 La Porte Ave.
Lee, Robert Y.....808 Lincolnway
Makovsky, Theodore.....808 Lincolnway
O'Neill, Martin.....810 LaPorte Ave.
Sacks, Leonard Z.....Porter Memorial Hosp.
Scheimann, Lois.....702 Lincolnway
Schmidt, Richard H.....Porter Memorial Hospital
Stoltz, Robert M.....501 Lincolnway
Tetrick, Lain.....Box 429
Vietzke, Paul C. F.....60 Jefferson St.

Gordon, Joseph L.....Wheeler

POSEY COUNTY

Montgomery, Samuel B. (S).....Cynthiana
Ropp, Harold E.....New Harmony
Boren, Paul R.....Poseyville
Boyle, Carroll L.....Poseyville

Mount Vernon

Challman, William B.....431 W. Third St.
Crist, John R.....105 E. Sixth St.
Hirsch, Herman L.....126 W. Fifth St.
Oliphant, Frank W.....701 Mulberry St.
Vogel, L. John.....131 W. Third St.

PULASKI COUNTY

Dublin, Madeline P.....Francesville
Lacy, John D., Jr.....Medaryville
Eshelman, Henry R.....Monterey

Winamac

Carneal, Thomas E. (S).....111 N. Monticello
Halleck, Harold J.....119 W. Main St.
Hollenberg, Edward L.....210 S. Market St.

Karns, John D.....105 N. Franklin
Thompson, William R.....111 N. Monticello

PUTNAM COUNTY

Veach, Lester W.....Bainbridge
Veach, Richard L.....Bainbridge
Gray, Clyde C. (S).....Cloverdale

Greencastle

Dester, Herbert E.....Box 76
Dettloff, Frederick.....Alamo Bldg.
Fuson, Wenfred J.....108 Northwood Blvd.
Johnson, James B.....105 E. Washington St.
Nichols, Anne Sackett.....707 E. Seminary St.
Schauwecker, Cleon M.....239 Hillsdale Ave.
Smith, A. Wilson.....DePauw University
Steele, Dick J.....Alamo Bldg.
Stephens, James P.....Alamo Bldg.
Tennis, George T.....Alamo Bldg.
Tipton, William R.....110 S. Vine St.
Wiseman, V. Earle.....239 Hillsdale Ave.

Byrne, Louis E.....Roachdale
Richards, Edgar E.....Russellville

RANDOLPH COUNTY

Nixon, Byron.....Farmland
White, Harvey E.....Farmland
Harmon, Wayne.....Lynn
Jordan, Leo E.....Lynn
Martin, Charles E. (S).....Lynn
Shallenberger, Henry R.....Modoc
Hinchman, Jean F.....Parker
Potter, Richard M.....Ridgeville

Union City

Birum, Patricia.....333 W. Oak St.
Chambers, Carol R.....Chambers Medical Clinic
Chambers, Leroy B.....Chambers Medical Clinic
Landon, David J.....R.R. #2
McClure, Morris E.....333 W. Oak St.
Phipps, Leland K.....227 W. Oak St.
Reid, Robert W. (S).....726 W. Division St.
Wagoner, B. D.....N. Columbia St.

Winchester

Dininger, William S.....102 E. South St.
Engle, Russell B.....210 S. Main St.
Koch, Howard W.....208 E. Washington St.
Painter, Lowell W.....124 E. Franklin St.
Slick, Crystal R.....457 Elm St.
Sparks, Paul W.....214 S. Main St.

Ruby, Fred McK. (S)
8128 Brookside Pl., Wauwatosa, Wis.

RIPLEY COUNTY

Hisrich, Lloyd W.....Batesville
Freeland, Bill E.....Batesville
Warr, William J.....Milan
Lippoldt, Charles L.....Oldenburg
Row, George S.....Osgood
Smith, R. Lee.....Osgood
McConnell, William C.....Sunman
Fletcher, Charles F. (S).....Sunman
Beebe, Milton O. Jr.....Versailles

RUSH COUNTY

McNabb, George B. Carthage
 McNabb, Richard C. Carthage
 Sheets, Charles E. Manilla
 Worth, C. Willard. Milroy

Rushville

Atkins, Clarence C. 225 N. Morgan St.
 Corpe, Kenneth F. R. R. No. 4
 Dean, Donald L. 4th & Main
 Denny, Melvin H. 127 W. Third St.
 Ellis, Davis W. 229 N. Morgan St.
 Green, Frank H. 134 E. Second St.
 Lee, John M. (S) 914 N. Morgan St.
 McKee, Harry G. 335 N. Main St.
 Norris, Marvin G. 134 E. Second St.
 Nutter, Wyndham H. 1003 N. Morgan

ST. JOSEPH COUNTY

Hartsough, Ralph L. Lakeville
 How, John T. (S) Lakeville

Mishawaka

Barone, Carmelo V. 307 W. Fourth St.
 Christophel, Verna. 109 W. Third St.
 Farner, James E. 114 Lincolnway E.
 Fujawa, Matthew J. 721 Lincolnway E.
 Ganser, Richard A. 111 S. Race St.
 Goethals, Charles J. 602 Lincolnway W.
 Mahank, Camiel C. 223 S. Spring St.
 Martin, Charles F. 322 S. Mill St.
 Reed, Robert F. 1316 Lincolnway E.
 Rosenwasser, Jacob. 225 Lincolnway E.
 Sirlin, Edward M. 109 S. Church St.
 Spalding, Wendell L. 427 Lincolnway E.
 Templeton, Ames R. 522 Calhoun St.
 Van Rie, Leo P. (S) 116 S. West St.
 Walerko, Frank. 124 S. Race St.
 Walters, Charles E. 319 S. Spring St.
 Whitlock, Francis C. 110 N. Race St.
 Whitlock, Merle E. 123 W. Fourth St.
 Wurster, Herbert C. 221 E. Third St.
 Zimmer, Henry J. 119½ Lincolnway W.

Luzadder, John E. New Carlisle
 Calvin, Helen M. P. O. Box 38, North Liberty
 Calvin, O. Walter P. O. Box 38, North Liberty
 Hardy, John J. (S) North Liberty
 Warrick, Homer L. Osceola

South Bend

A

Acker, Robert B. (S) 418 Sherland Bldg. (1)
 Arisman, Ralph K. 607 Odd Fellows Bldg. (1)

B

Backs, Alton J. 1401 Lincolnway W. (28)
 Baran, Charles. 404 Sherland Bldg. (1)
 Bartsch, Harvey L. 919 E. Jefferson Blvd., #102 (17)
 Bechtold, Samuel E. 919 E. Jefferson Blvd., #302 (17)
 Bell, Horace D. 420 N. Hill St. (17)
 Bennett, Jene R. 531 N. Main St. (1)
 Berke, Robert D. 1118 Lincolnway E. (18)
 Biasini, Benedict A. 403 Dixie Way North (17)
 Bickel, David A. 515 Odd Fellows Bldg. (1)
 Birmingham, Peter J. (S) 426 Sherland Bldg. (1)
 Bixler, Louis C. 919 E. Jefferson Blvd., #207 (17)

G

Blackburn, Erwin. 402 Sherland Bldg. (1)
 Bodnar, Leslie M. 525 N. Michigan (1)
 Bogan, William C. 316 N. Ironwood (15)
 Booth, Franklin M. 430 Sherland Bldg. (1)
 Borough, Lester D. 710 J. M. S. Bldg. (1)
 Brechtel, Harvey J. 919 E. Jefferson Blvd., #104 (17)

Buchanan, Wallace D.

919 E. Jefferson Blvd., #107 (17)
 Buechner, Frederick W. 116 N. Main St. (1)
 Buslee, Roger M. 531 N. Main Street (1)
 Bussard, Clifford F. (S) 202 Whitcomb-Keller Bldg. (1)
 Bussard, Frank W. 202 Whitcomb-Keller Bldg. (1)
 Butts, Milton A. 118 N. Walnut St. (28)

C

Carter, F. R. Nicholas. 605 Sherland Bldg. (1)
 Cassady, James V. 921 Lincolnway E. (18)
 Cassady, John R. 921 Lincolnway E. (18)
 Chamblee, Roland W. 336 N. Notre Dame (17)
 Clark, Stanley A. (S) 1242 E. Jefferson Blvd. (17)
 Clark, William H. 520 Sherland Bldg. (1)
 Colip, George D. 514 Sherland Bldg. (1)
 Colosey, Frederick J. 3121 Mishawaka Ave. (15)
 Conklin, Raymond L. 215 Swanson Circle W. (15)
 Cook, Gordon C. 719 N. Main St. (1)
 Cooper, Harry L. (S) 410 Sherland Bldg. (1)
 Crowley, Joseph B. Notre Dame Univ.
 Culbertson, Carl S. 531 N. Main St. (1)
 Custer, Edward W. Healthwin Hospital (17)

D

Davis, Edward A. 3014 Ardmore Trail
 Denham, Robert H. 919 E. Jefferson Blvd., #204 (17)
 Devoe, Kenneth. 418 N. Michigan St. (1)
 Dietl, Ernest L. 820 Sherland Bldg. (1)
 Dingley, Albert F. 919 E. Jefferson Blvd., #204 (17)
 Dodd, Robert D. 2311 Miami St. (14)
 Dolezal, Bernard J. 115 S. Eddy St. (17)
 Donnelly, Everett F. 602 N. Michigan St. (1)
 Dunlap, D. Logan. 203 J. M. S. Bldg. (1)

E

Eades, R. Charles. 527 Colfax (17)
 Ebin, Judah L. 816 Odd Fellows Bldg. (1)
 Edwards, Bernard E. 704 N. Main St. (1)
 Egan, Sherman. 203 J. M. S. Bldg. (1)
 Engel, Howard R. 919 E. Jefferson Blvd., #403 (17)
 English, John P. 122 N. Lafayette Blvd. (1)
 Ericksen, Lester G. 919 E. Jefferson Blvd., #207 (17)
 Erickson, Gustaf W. 122 N. Lafayette Blvd. (1)

F

Feferman, Martin E. 919 E. Jefferson Blvd., #305 (17)
 Feldman, Max. 1921 Miami St. (14)
 Filipek, Walter J. 311 Odd Fellows Bldg. (1)
 Firestein, Ben Z. 919 E. Jefferson Blvd., #307 (17)
 Firestein, Ray. 416 Sherland Bldg. (1)
 Fish, Edson C. 326 Sherland Bldg. (1)
 Fisher, Lawrence F. (S) 1717 E. Colfax (17)
 Frank, Herbert. 919 E. Jefferson Blvd., #202 (17)
 Frank, Lyall L., Jr. 224 W. Navarre (1)
 Frank, Lyall L. 224 W. Navarre (1)
 Frash, DeVon W. 1910 Miami (14)
 Frey, William B. 316 N. Ironwood Dr. (15)
 Friedman, Morris S. 919 E. Jefferson Blvd., #402 (17)
 Frith, Louis G. 521 W. Washington Ave. (1)

G

Gaffney, Raymond. 535 W. Colfax Ave. (1)
 Gates, George E. 122 N. Lafayette Blvd. (1)
 Gilman, Marcus M. 401 Odd Fellows Bldg. (1)
 Godersky, George E. 919 E. Jefferson Blvd., #106 (17)
 Graf, John P. 326 Sherland Bldg. (1)

Green, George F. 825 Sherland Bldg. (1)
 Green, Norval E. 704 N. Main St. (1)
 Grillo, Donald. 723 Sherland Bldg. (1)
 Grorud, Alton C. 122 Lafayette Blvd. (1)
 Grove, James H. 919 E. Jefferson Blvd., #107 (17)

H

Haley, Paul E. 816 Sherland Bldg. (1)
 Hall, James M. 230 Sherland Bldg. (1)
 Hamilton, Charles O. 602 N. Michigan (1)
 Hanley, Harriet F. 919 E. Jefferson Blvd., #101 (17)
 Haugseth, Ellsworth K. 122 Lafayette Blvd. (1)
 Hawkins, Glen E. 602 N. Michigan (1)
 Helmer, John F. 826 Sherland Bldg. (1)
 Hilbert, John W. 410 W. Washington Ave. (1)
 Hildebrand, John O. 1307 E. Ewing Ave. (14)
 Hill, Theodore A. 107 N. Eddy (17)
 Hill, Wallace C. 919 E. Jefferson Blvd., #306 (17)

Hillman, Marion W. 206 E. Bartlett St. (1)
 Hillman, William H. (S) 1317 Marquette Blvd. (16)

Holdeman, Lillian S. 404 N. Lafayette Blvd. (1)
 Holdeman, Richard W. 404 N. Lafayette Blvd. (1)
 Holtzman, Norman N. 3123 S. Michigan (14)
 Houser, D. Stanley. 2314 Miami (14)
 How, Louis E. 60149 U. S. 31
 Hyde, Carroll C. 122 N. Lafayette Blvd. (1)

J-K

Johns, Nicholas C. 116 E. Jefferson Blvd. (1)
 Kamm, Bernard A. 526 Sherland Bldg. (1)
 Karn, John W. 326 Sherland Bldg. (1)
 Knapp, Arthur L. (S) 2215 Mishawaka Ave. (15)
 Knode, Kenneth T. 729 Sherland Bldg. (1)
 Krueger, John E. 326 Sherland Bldg. (1)
 Kuhn, Frederick L. 1215 S. Michigan (18)

L

Lamb, J. Leonard 919 E. Jefferson Blvd., #401 (17)
 Lane, William H. 418 N. Main St. (1)
 Lang, Joseph E. 318 Sherland Bldg. (1)
 Lester, Vern L. 919 E. Jefferson Blvd., #107 (17)
 Levatin, Bernard I. 919 E. Jefferson Blvd., #303 (17)
 Levkoff, Abner H. 919 E. Jefferson Blvd., #101 (17)
 Lionberger, John R. 919 E. Jefferson Blvd., #207 (17)
 Lockhart, Philip B. 919 E. Jefferson Blvd., #107 (17)

M

MacLeod, John K. 120 N. Lafayette Blvd. (1)
 Marquis, Gordon. 120 N. Lafayette Blvd. (1)
 Mason, Bernard A. 122 N. Lafayette Blvd. (1)
 Maury, Merritt C. 919 E. Jefferson Blvd. (17)
 McCraley, William J. 218 S. Francis (17)
 McDonald, Ralph M. 502 J. M. S. Bldg. (1)
 McFarland, Corley B. 122 N. Lafayette Blvd. (1)
 McMeel, James. 1138 Whitehall Dr.
 Metcalfe, Grant E. 919 E. Jefferson Blvd., #308 (17)

Miller, Milo K. (S) 122 N. Lafayette Blvd. (1)
 Mott, Cassell A. 1301½ W. Washington St. (16)
 Mueller, Hilbert M. 122 N. Lafayette Blvd. (1)
 Murphy, Eugene C. 122 N. Lafayette Blvd. (1)
 Murphy, Josephine F. 111 W. Bartlett St. (1)

N-O

Neher, John L. 17615 State Rd. 23
 Nelson, F. Dale. 704 N. Main St. (1)
 Nelson, Raymond E. 206 E. Bartlett St. (1)

Olson, Donald T. 919 E. Jefferson Blvd., #309 (17)
 Olson, Kenneth L. 919 E. Jefferson Blvd., #207 (17)
 Oren, William F. 919 E. Jefferson Blvd., #301 (17)
 Orr, W. Robert 525 N. Michigan St. (1)

P

Parsons, Robert L. 919 E. Jefferson Blvd. (17)
 Pauszek, Thomas B. 726 W. Washington St. (16)
 Petrass, Andrew. 516 Sherland Bldg. (1)
 Phelps, Stephen R. 818 Sherland Bldg. (1)
 Plain, George. 122 N. Lafayette Blvd. (1)
 Proudfit, Charles H. 919 E. Jefferson Blvd., #304 (17)
 Pyle, Harold D. 119 S. Eddy St. (17)

R

Rasmussen, Ruth F. 122 N. Lafayette Blvd. (1)
 Rigley, Edward L. 408 Sherland Bldg. (1)
 Roberts, Billy J. 3123 Mishawaka Ave. (15)
 Rodin, Herman H. 1112 S. 20th St.
 Rosenheimer, George M. 418 N. Michigan St. (1)
 Rubens, Eli. 2314 Miami (14)
 Rudolph, Carl J. 110 W. Bartlett St. (1)

S

Sanderson, Robert B. 730 Sherland Bldg. (1)
 Sandock, Isadore. 819 E. Napoleon St. (17)
 Sandock, Louis F. 428 Sherland Bldg. (1)
 Sandoz, Harry H. 612 Odd Fellows Bldg. (1)
 Schaphorst, Richard A. 1124 Whitehall Dr. (15)
 Schiller, Herbert A. 919 E. Jefferson Blvd., #205 (17)
 Scott, Frank M. 122 N. Lafayette Blvd. (1)
 Selby, Keith E. 407 Lincolnway W. (1)
 Sellers, Francis M. 3209 Mishawaka Ave. (15)
 Sensenich, Roscoe L. (H) 128 S. Scott St. (25)
 Sharp, Merle C. 717 N. Main St. (1)
 Shelley, Edward S. 207 S. Taylor (25)
 Shriner, Richard L. 919 E. Jefferson Blvd., #308 (17)
 Sisson, Norvel D. 531 N. Main St. (1)
 Skillern, Penn G. (S) 1014 E. Fox St. (14)
 Skillern, Scott D. 422 Sherland Bldg. (1)
 Slominski, Harry H. (S) 708 Odd Fellows Bldg. (1)
 Spenner, Raymond W. 726 Sherland Bldg. (1)
 Staunton, Henry A. 3016 Mishawaka Ave. (15)
 Stiver, Daniel D. 822 Sherland Bldg. (1)
 Stogdill, William J. 525 Sherland Bldg. (1)

T

Taylor, M. Reed, Jr. 621 N. Main St.
 Thompson, John M. 921 Lincolnway E. (18)
 Thompson, Robert A. 913 S. Twyckenham Dr. (15)
 Thornton, Maurice J. 919 E. Jefferson Blvd., #107 (17)
 Tirman, Wallace S. 919 E. Jefferson Blvd., #207 (17)
 Traver, Perry C. (S) 1010 Riverside Dr. (16)

V-W-X-Y-Z

Vagner, S. Bernard 1303½ W. Washington Ave. (16)
 Vurpillat Francis J. 132 N. Lafayette Blvd. (1)
 Wack, James E. 530 W. Indiana Ave. (14)
 Walker, Edwin M., Jr. 326 Sherland Bldg. (1)
 Ward, James W. 325 Wakewa (17)
 Weiss, Eugene. 919 E. Jefferson Blvd. (17)
 White, Donald G. 18283 Ireland Road
 Wilhelm, Agatha M. 1032 E. Wayne at Eddy (17)
 Wilson, James M. 919 E. Jefferson Blvd. (17)

Wixted, John F. 919 E. Jefferson Blvd. (17)
 Wixted, Julia L. 919 E. Jefferson Blvd. (17)
 Zeiger, Irvin. 3123 Mishawaka Ave. (15)

Carter, William D. 506 Roosevelt Rd., Walkerton
 Rohrer, Bryce B. 506 Roosevelt Rd., Walkerton
 Skeen, Earl D. (S) Walkerton
 Cline, Kenneth L. Wyatt

Bassler, Carl R. (S) R. #4, Niles, Michigan
 Ellison, Alfred. 7304 Encelia Dr., La Jolla, Calif.
 Fish, Clyde M. (S) R. R. 2, Edwardsburg, Mich.
 Liss, Emanuel C.

112-20 72nd Dr., Forest Hills, New York
 Smith, Lee Jr. Brethren Service Project
 Castaner, Puerto Rico
 Stratigos, Joseph S. 736 Judson, Evanston, Ill.

SCOTT COUNTY

Bogardus, Carl R. Austin
 McClain, Marvin L. 935 First St., Scottsburg
 Napper, Floyd S. 69 Wardell St., Scottsburg
 Sabens, James A. 69 Wardell St., Scottsburg

SHELBY COUNTY

Nigh, Rufus M. Fairland
 Davis, John A. Flat Rock

Shelbyville

Arata, Lucian A. 327 W. Broadway
 Dalton, Wilson L. 117 W. Washington St.
 Inlow, Herbert H. 103 W. Washington St.
 Inlow, William D. (S) 103 W. Washington St.
 Miller, Richard C. 17 Mechanic St.
 Moheban, Joseph. 120 W. Jackson St.
 Paz, Luis. 103 W. Washington St.
 Richard, Norman F. 103 W. Washington St.
 Scott, V. Brown. 103 W. Washington St.
 Silbert, David B. 17 S. Tompkins
 Spindler, Robert D. 165 W. Mechanic St.
 Tindall, Paul R. (S) 20 N. Pike St.
 Tindall, William R. 505 S. Harrison St.
 Tower, James H., Jr. 120 W. Jackson St.
 Travis, Floyd D. 103 W. Washington St.
 Whitcomb, Roger F. 302 Methodist Bldg.

SPENCER COUNTY

Barrow, John H. Dale
 Medcalf, Norman L. (S) Lamar
 Jolly, Wesley P. (S) Richland
 Atchison, Kenneth C. (S) Rockport
 Glackman, John C., Jr. Rockport
 Monar, Michael Rockport

STARKE COUNTY

Leinbach, Earl Hamlet

Knox

DeNaut, James F. 4 N. Heaton St.
 Henry, Howard J. 107 S. Main St.
 Ingwell, Guy B. 201 S. Heaton St.
 McClure, Clark. 107 S. Main St.

North Judson

Llamas, Dominador F. 520 Lane St.

STEUBEN COUNTY

Angola

Artz, Richard W. 416 E. Maumee
 Barton, Robert 416 E. Maumee
 Cameron, Don F. 416 E. Maumee
 Cameron, Mary H. 416 E. Maumee
 Crum, Marion M. 301 E. Maumee

Davis, Claude E. 909 W. Maumee
 Hartman, John J. 299 W. Felicity
 Kissinger, Knight L. Elmhurst Hospital
 Mason, Donald G. 416 E. Maumee
 Rausch, Norman W. 416 E. Maumee

Mittleman, Edwin J. Box 14, Ashley
 Blosser, Blaine A. (S) Fremont
 McCormack, Lloyd L. Fremont
 Alford, James A. Hamilton
 Schrepferman, Wayne Hamilton

SULLIVAN COUNTY

Brown, John S. Carlisle
 Whipps, Charles E. (S) Carlisle
 Dukes, Betty Dugger
 Dukes, Frederic M. (S) Dugger
 Dukes, Joe E. Dugger
 Bethea, Robert O. Farmersburg

Sullivan

Bedwell, Marion H. 16 N. Court St.
 Crowder, James H. 112 N. Section St.
 Eskew, Kenneth W. 117 W. Washington St.
 Higbee, Paul (S) 4 E. Washington St.
 Maple, James B. (S) 117 W. Washington St.
 McClure, Glenn 342 S. Main St.
 Scott, Irvin H. 117 W. Washington St.

Taylor, John R. 105 N. Main, Palestine, Ill.
 Daugherty, William L. Hutsonville, Ill.

SWITZERLAND COUNTY

(See Jefferson-Switzerland)

TIPPECANOE COUNTY

Lafayette

Ade, Charles H. 2211 South St.
 Ade, Mary Keller. 2211 South St.
 Baker, John R. 405 Lafayette Life Bldg.
 Balkema, Catherine M. 3 N. 21st St.
 Bayley, William E. Home Hospital
 Bolin, Robert C. 308 N. Eighth St.
 Buhrmester, Harry C., Jr. 308 N. Eighth St.
 Burkle, John C. (S) 520 Wall St., #7
 Burns, John T. 2502 South St.
 Bush, Jack A. 405 Lafayette Life Bldg.
 Calvert, Raymond R. 314 N. Sixth St.
 Canganelli, Vincent G. 2433 South Ninth St.
 Carpenter, James B. 15 N. 25th St.
 Cole, Ira 2315 South St.
 Coyner, Alfred B. 509 Lafayette Life Bldg.
 Davis, Howard B. 308 N. Eighth St.
 Deur, Julius. 1011 Columbia
 Donahue, George R. 718 Lafayette Life Bldg.
 Dubois, Ramon B. 23 N. 25th St.
 Eaton, Marion J. 214 Lafayette Life Bldg.
 Elliott, Paul W. 35 N. 25th St.
 Engeler, James E. 308 N. Eighth St.
 Ferguson, William B. 2211 South St.
 Fields, Donald C. 312 N. Eighth St.
 Flack, Russell A. 1005 Lafayette Life Bldg.
 Frasch, Mahlon G. 300 Lafayette Life Bldg.
 Frey, Harley B. 405 Lafayette Life Bldg.
 Gery, Richard E. 308 N. Eighth St.
 Gripe, Richard P. 308 N. Eighth St.
 Haas, Charles F. 2211 South St.
 Harden, Murray E. 903 Lafayette Life Bldg.
 Harter, Eli B. 312 N. Eighth St.
 Harvey, Bennett B. 35 N. 25th St.
 Herrold, George W. 20 N. 24th St.
 Hogle, Frank D. Wabash Valley Sanitarium
 Holladay, Lloyd J. 411 Lafayette Life Bldg.
 Horswell, Richard R. 312 N. Eighth St.
 Hughes, Richard R. 31 N. 25th St.

Hull, James E.....2211 South St.
Hunsberger, Walter G.....St. Elizabeth Hospital
Hunter, Frank P. (S).....617 Lafayette Life Bldg.
Johnson, Herbert S.....312 N. Eighth St.
Johnson, Lowell R.....2315 South St.
Jones, David.....24 N. 24th St.
Karberg, Richard J.....2420 Ferry St.
Klatch, Ben Z.....2211 South St.
Klepinger, Harry E.....824 Lafayette Life Bldg.
Kohne, Robert W.....3010 Underwood
Landis, Charles B.....2211 South St.
Laws, Kenneth F.....501 Lafayette Life Bldg.
Levering, Guy P. (S).....2113 S. Eighth St.
Loop, Frederick A.....2211 South St.
McAdams, Hugh B.....2011 Kossuth St.
McAdams, Robert.....2011 Kossuth St.
McClelland, Donald C. (S).....312 N. Eighth St.
McFadden, James M.....35 N. 25th St.
McKinley, Joseph.....312 Lafayette Life Bldg.
McKinney, Daniel H.....301 Lafayette Life Bldg.
Marsh, George W.....1216 Howell
Martin, Joe M.....920 Lafayette Life Bldg.
Marvel, Howard R.....308 N. 8th St.
Mather, Charles R.....312 N. 8th St.
Mather, Robert L.....609 Lafayette Life Bldg.
Miller, Roland E.....2200 Scott St.
Mount, William M.....20 N. 24th St.
Neumann, Kenneth O.....618 Lafayette Life Bldg.
Onorato, Joseph J.....2433 S. Ninth St.
Pearlman, Samuel S. (S).....107 N. Sixth St.
Peterson, Joel A.....609 Lafayette Life Bldg.
Peyton, Frank W.....15 N. 25th St.
Ratcliff, Frank W.....405 Lafayette Life Bldg.
Rothrock, Philip W.....2200 Scott St.
Ruschli, Edward B. (S).....510 Lafayette Life Bldg.
Shively, John L.....2211 South St.
Sholtz, William M.....405 Lafayette Life Bldg.
Smith, Lowell C.....637 Ferry St.
Stahl, Edward T.....308 N. Eighth St.
Stansell, Gilbert B.....St. Elizabeth Hosp.
Steele, Hugh H.....308 N. Eighth St.
Strayer, Joseph W.....612 Lafayette Life Bldg.
Stuntz, Edgar C.....Wabash Valley Hospital
Trout, Carl J.....314 N. Sixth St.
Tubbs, George R. (S).....2502 Iroquois Trail
Underwood, George M.....

Jefferson Sq. Shopping Center

Van Buskirk, Edmund L.....308 N. Eighth St.
Van Den Bosch, Wallace R.....2216 South St.
Vermilya, Robert W.....405 Lafayette Life Bldg.
Weaver, Richard J.....St. Elizabeth Hosp.
Williams, Robert E.....15 N. 25th St.
Williams, Russell S.....308 N. 8th St.

Babb, Forrest J.....Stockwell

West Lafayette

Ash, Harold H.....712 Bexley Rd.
Bahler, Dean R.....1320 West State St.
Carroll, Bertha Rose.....Purdue University
Combs, Loyal W.....Purdue University
Crockett, Franklin S. (H).....424 Littleton St.
Hass, Caroline E.....402 Northwestern Ave.
Hass, Thomas W.....402 Northwestern Ave.
MacLeod, Donald F.....Purdue University
McCabe, James E.....Soldiers Home
Meikle, Louise J. (S).....606 Terry Lane
Rommel, Clarence H.....456 Northwestern
Schmiedicke, Paul H.....Purdue University
Wilms, John H.....Purdue University

TIPTON COUNTY

Haller, Robert L.....Kempton
Stouder, Albert E.....Kempton
Tranter, William F.....Sharpsville

Tipton

Burkhardt, Boyd A.....202 S. West St.
Carter, Jean V.....130 N. Main St.
Compton, George L.....219 N. Independence
Gossard, Meredith B.....308 N. Independence
Kincaid, Raymond K.....202 S. West St.
Kurtz, William A.....202 S. West St.

Ericson, Harold L.....Windfall
Moser, Elmer B. (S).....Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

Evansville

A

Acre, Robert R.....706 Walnut St. (8)
Adler, Raymond N.....714 Second Ave. (10)
Adey, Wallace M.....1307 N. Stringtown Rd. (11)
Alexander, John E.....609 Hulman Bldg. (8)
Anderson, Milton H.....Evansville State Hosp. (2)
Antes, Earl H.....420 Cherry St. (13)
Arendell, Robert E.....1400 Cass Ave. (14)
Austin, Eugene W.....3700 Belle Meade (15)
Austin, M. A. (S).....3900 Washington Ave. (15)

B

Baker, Herman M. (S).....715 First Ave. (10)
Baker, Mason R.....1008 S. Evans Ave. (13)
Barclay, Irvin C.....114 S. E. Second St. (8)
Barnhart, Willard T.....701 Chestnut St. (13)
Baylor, Edward M.....501 E. Cherry St. (13)
Beck, Robert E.....600 Mary St. (10)
Begley, Joseph W. Jr. 314 S. E. Riverside Dr. (13)
Bender, Martin J.....912 Hulman Bldg. (8)
Bennett, Abner P.....412 S. E. Fourth St. (13)
Bissonnette, Roger P.....420 Cherry St. (13)
Boone, Robert D.....420 Cherry St. (13)
Boswell, Robert W. C.....2351 Division St. (14)
Boyd, Stella N.....502 Hulman Bldg. (8)
Brakel, Frank J.....420 Cherry St.
Britt, Robert.....420 Cherry St. (13)
Brockmole, Arnold W.....201 S. E. Third St. (13)
Brown, George W.....

Mead Johnson & Co., 2404 Penn. (21)

Brown, Robert L.....2509 Washington Ave. (14)
Bryan, Stanton L.....607 Hulman Bldg. (8)
Buehner, Donald F.....3700 Bellemeade
Burger, Thomas C.....3700 Bellemeade (15)
Burnikel, Ray H.....527 Sycamore St. (8)
Burriss, Clyde R.....723 Mary St. (10)

C

Cacia, John J.....609 Hulman Bldg. (8)
Caldwell, William C. (S).....
504 Old National Bank Bldg. (8)
Carlson, Ralph F.....517 Sycamore St. (8)
Cheydleur, Eleanor P.....

314 S. E. Riverside Dr. (13)

Clark, Thomas W.....420 Cherry St. (13)
Clouse, Paul A.....613 S. Weinbach Ave. (14)
Cockrum, William M.....908 Hulman Bldg. (8)
Cole, William L.....10 N. Weinbach (11)
Coleman, Joseph E.....3700 Bellemeade (15)
Combs, Herman T.....807 W. Indiana (10)
Combs, John H.....412 S. E. Fourth St. (13)
Combs, Pearl B. (S).....4109 Lincoln (15)
Cooper, Waller W.....Deaconess Hospital (10)
Corcoran, Patrick J. V.....3700 Bellemeade (15)
Crawford, James H.....221 Chestnut St. (13)
Crevello, Albert J.....3700 Bellemeade (15)
Crimm, Paul D.....Boehne Hospital (12)
Crudden, Charles H.....Clearview Sanitarium (10)
Cuff, Steve C.....420 Cherry St. (13)
Cullnane, Chris W.....2312 W. Franklin St. (12)
Cymbala, Bohdan.....St. Mary's Hospital (10)

D

Daves, William L.
608 Old National Bank Bldg. (8)
Davidson, Harold H. 420 Cherry St. (13)
Deems, Myers B. 314 S. E. Riverside Dr. (13)
Denzer, Edward K. 108 S. E. Second St. (8)
Denzer, William O. 108 S. E. Second St. (8)
Dieckman, Herbert S. 3700 Bellemeade (15)
Diefendorf, Charles F. (S)
2100 W. Virginia St. (12)
Dodd, Roberts K. 2605 Lincoln Ave. (14)
Downer, Luther H. 521 Oak Street (13)
Drake, Dale W. St. Mary's Hospital (10)
Dunham, Henry H. 715 First Ave. (10)
Durkee, Melvin S. 3700 Bellemeade (15)
Durkin, John W., Jr. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Dycus, Walter A. 319 N. St. Joseph Ave. (12)
Dyer, Wallace K. 221 Chestnut St. (13)

E

Eisterhold, John A. 5300 New Harmony Rd. (12)
Engel, Edgar L. 126 S. E. Seventh St. (8)
Ewer, Robert W. 420 Cherry St. (13)

F

Faith, Ira L. 805 Old Nat'l. Bank Bldg. (8)
Faul, Henry J. 815 Hulman Bldg. (8)
Faw, Melvin L. 420 Cherry St. (13)
Fenneman, Robert J. 402 S. E. Seventh St. (8)
Fickas, Dallas. 715 First Ave. (10)
Fisher, William C. 715 First Ave. (10)
FitzGerald, Maurice D. 924 Bayard Park Dr. (13)

G

Garland, Edgar A. 606 S. Weinbach (14)
Gaul, L. Edward. 509 Hulman Bldg. (8)
Getty, William H. 420 Cherry St. (13)
Giorgio, Douglas J. 916 S. Burkhardt Rd. (15)
Gow, Robert C. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Griep, Arthur H. 5414 Madison Ave. (15)
Grimm, William C. H. 420 Cherry St. (13)
Guckien, Joseph L. 609 Hulman Bldg. (8)

H

Hammond, R. Case. 701 Chestnut St. (13)
Hare, Daniel M. 706 Walnut St. (8)
Harlan, William L. 3700 Bellemeade Ave. (15)
Harned, Ben K. 420 Cherry St. (13)
Harris, Robert L. 4 Woodmere Lane (15)
Hart, L. Paul. 3700 Bellemeade Ave. (15)
Hartley, Clarence A., Jr. 221 Chestnut St. (13)
Hartz, F. Minton. 123 S.E. Second St. (8)
Heard, Albert. 322 E. Cherry St. (13)
Heinrich, Weston A. 314 S. E. Riverside Dr. (13)
Hendershot, Eugene L. 412 S. E. Fourth St. (13)
Hermayer, Stephen. 220 S. E. Seventh St. (13)
Herrmann, Gordon T. 3700 Bellemeade (15)
Herzer, Clarence C. 322 N. Fulton (10)
Himebaugh, Gilbert. 3700 Bellemeade (15)
Hobbs, Arthur A. 600 Mary St. (10)
Hoopes, Jane M. 3700 Bellemeade (15)
Hoover, J. Guy. 517 Sycamore St. (8)
Hotalen, William B. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Hovda, Richard B. St. Mary's Hospital (15)
Huggins, Victor S. 715 First St. (10)
Hyatt, Gilbert T. 1106 W. Franklin St. (10)

J

Johnson, Gardner C. (S)
3900 Washington Ave. (15)
Johnson, Harold V. 2114 W. Franklin St. (12)
Johnson, Stephen L. 521 Sycamore St. (8)

K

Kauffman, Harley M. 219 Walnut St. (8)
Kelly, John B. 420 Cherry St. (13)
Kessler, Robert B. 1338 Division St. (14)
Kiechle, Frederick L. 726 S. E. First St. (13)
Kincaid, Robert S. 1000 N. Spring St. (11)
Kleindorfer, Roscoe L. 819 W. Franklin St. (10)

L

Laubscher, Clarence. 6621 Kratzville Rd. (10)
Lawrence, Joseph C. 413 First Ave. (10)
Leibundguth, Henry. 3700 Bellemeade (15)
Leich, Charles F. 124 S. E. First St. (8)
Lewis, Earl T. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Lynch, Harold D. 216 S. E. Riverside Dr. (13)

M

McCool, Joseph H. 715 First Ave. (10)
McCoy, Melvin H. 3013 Broadway (12)
McDonald, Joseph D. 517 Sycamore St. (8)
McKeon, Edward C. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
MacKenzie, Pierce. 126 S. E. Seventh St. (8)
Manner, Richard J. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Marchand, John H., Jr. 420 Cherry St. (13)
Marvel, James A. 420 Cherry St. (13)
Mason, Everett E. 118 S. E. First St. (8)
Mathews, James R. 118 S. E. First St. (8)
Maxson, Roy V. 401 Mary St. (10)
Mayberry, Alton. 3700 Bellemeade (15)
Miller, Laverne B. 714 N. Main St. (11)
Miller, Milton J. 15 W. Franklin St. (10)
Mills, Fred E. Deaconess Hospital (10)
Mino, Robert A. 723 Mary St. (10)
Moehlenkamp, Charles E.
614 N. Governor St. (11)
Moulton, Lillian G. 1 North Barker (12)
Muelchi, Adeline F. 518 Hulman Bldg. (8)
Murphy, Edward U. 901 Hulman Bldg. (8)

N

Nenneker, Henry (S) 1912 Harmonyway (12)
Newman, Alvin E. 912 Hulman Bldg. (8)
Newsome, C. K. 415 E. Mulberry (13)
Nicholson, Raymond W. 3700 Bellemeade (15)
Niedermayer, Alfred J. 960 Washington Ave. (13)
Nonte, Leo R. 715 First Ave. (10)

O

Oswald, Robert H. 126 S. E. Seventh St. (8)

P

Pastor, Julius W. 3700 Washington Ave. (15)
Pemberton, Jack J. 319 N. St. Joseph Ave. (12)
Pollard, Walter S. (S) 115 S. E. Second St. (8)
Porro, Francis W. 3700 Washington Ave. (15)
Present, Julian. 3700 Bellemeade (15)
Price, Shirley G. 420 Cherry St. (13)
Pugh, Willis L. 715 First Ave. (10)

R

Ratcliffe, Albert W. 510 S. E. First St. (13)
Reich, Clarence E. 1209 N. Fulton (10)
Rietman, H. Jerome
Evansville State Hospital (2)
Ritchie, William D. 555 Herndon Dr. (11)
Rittlemeyer, Louis F., Jr. Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Ritz, Albert S. 3700 Bellemeade (15)
Robinson, Earle U. 615 Bellemeade (13)
Rosenblatt, Bernard B. 709 Hulman Bldg. (8)
Royster, George M. (S)
401 Citizens Nat'l. Bank Bldg. (8)
Royster, Robert A.
401 Citizens Nat'l. Bank Bldg. (8)
Rupper, Warren R. 600 Mary Street (10)
Rusche, Henry J. 313 W. Iowa (10)
Russell, Richard H. 3700 Washington Ave. (15)

S

Schimmelpfennig, Robert W. 1013 Parrett St. (13)
 Schirmer, Robert H. 1118 W. Franklin St. (12)
 Schneider, Charles P. 2211 W. Franklin St. (12)
 Schriefer, Victor V. 1120 N. Main St. (11)
 Sinn, Charles M. 715 First Ave. (10)
 Slaughter, Howard C. 908 Hulman Bldg. (8)
 Slaughter, John C. 3700 Bellemeade (15)
 Slaughter, Owen L. 3700 Bellemeade (15)
 Smith, Roy M. 1307 Stringtown Rd. (11)
 Snively, William D., Jr. Mead Johnson & Co.,
 2404 Pennsylvania St. (21)
 Sprecher, Herman C. 527 Sycamore St. (8)
 Springstun, Walter R. 715 First Ave. (10)
 Stallings, Hugh A. 3700 Bellemeade (15)
 Steele, Paul W. 1218B Lincoln Ave. (14)
 Sterne, John H. 3700 Bellemeade (15)
 Stork, Urban 420 Cherry St. (13)
 Strueh, Paul E. 220 S. E. Seventh St. (13)

T

Tager, Stephen N. 3700 Bellemeade (15)
 Thompson, Naiad Mason 420 Cherry St. (13)
 Tilden, Margaret H. 700 Mary St. (10)
 Tisserand, John B., Jr. 3700 Bellemeade (15)
 Tuholski, James M. Mead Johnson & Co.,
 2404 Pennsylvania St. (21)
 Turner, Isabel B. 2208 E. Walnut St. (14)
 Tweedall, Daniel C. 715 First Ave. (10)

U-V

Viehe, Robert W. 618 S. Willow Rd. (14)
 Visher, John W. 805 Old National Bank Bldg. (8)
 VonderHaar, Thomas E. 715 First Ave. (10)

W

Walker, William F. 420 Cherry St. (13)
 Walter, Paul A. F., III. Mead Johnson & Co.,
 2404 Pennsylvania St. (21)
 Walter, Robert F. 1514 S. Kentucky Ave. (14)
 Warner, Charles L. 420 Cherry St. (13)
 Waters, George W. Evansville State Hospital (2)
 Weber, Edgar H. 123 S. E. Second St. (8)
 Weiss, Henry G. 614 Hulman Bldg. (8)
 Welborn, Mell B. 420 Cherry St. (13)
 Wilhelmus, C. Kenneth. 115 S. E. Seventh St. (8)
 Wilhelmus, Gilbert M. 1028 Washington (15)
 Willis, Charles F. 1100 S. Bedford Ave. (13)
 Willison, George W. 3700 Bellemeade (15)
 Wilson, David. 517 Mary St. (10)
 Wilson, John D. 3700 Bellemeade (15)
 Wilson, Ralph. 517 Mary St. (10)
 Woods, Arba L. (S) 2921 Graham Ave. (14)
 Woods, William P. (S) 5050 Lincoln Ave. (15)
 Wynn, Justice F. 905 Hulman Bldg. (8)

X-Y-Z

Young, C. Curtis. 126 S. E. Seventh St. (8)
 Zeier, Francis G. 420 Cherry St. (13)
 Zimmerman, Harold. 6 S. E. Second St. (8)
 Ziss, Robert C. 216 S. E. Riverside (13)
 Zwickel, Ralph E. 906 Hulman Bldg. (8)

Buchholz, Ransom R.
 V. A. Hospital, McKinney, Texas
 Ehrich, William S. (S)
 Hillcrest, Pawleys Island, S. C.
 Jernigan, William R. 756 Loeb, Memphis, Tenn.
 Lyman, Frank L.
 1 Sherman Ave., White Plains, N. Y.
 Miller, Robert J. Box 698, Poplar, Mont.
 Steckler, Robert J.
 9871 Aldgate, Garden Grove, Calif.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B. New Goshen
 McIntosh, Wilbert Riley
 Jett, Clyde W. Seelyville

Terre Haute

A

Allen, Orris T. (S) 422 Rose Dispensary Bldg.
 Anderson, Walter C. 2235 Wabash Ave.
 Ault, Roy 3050 Poplar St.

B

Baldrige, William O. 12 Points State Bank Bldg.
 Bannon, William G. 416 Rose Dispensary Bldg.
 Benages, Anthony G. 221 S. Sixth St.
 Blum, Leon L. 210 Rose Dispensary Bldg.
 Bopp, Henry, Jr. 221 S. Sixth St.
 Bopp, James. 236 S. 21st St.
 Boyd, H. Clark. 221 S. Sixth St.
 Bradley, Stephen C. (S) 916 S. 25th St.
 Bronson, Paul J. 3050 Poplar St.
 Brown, Robert R. 221 S. Sixth St.

C

CaJacob, Melville E. 1000 S. Sixth St.
 Caldwell, Milton V. 721 Wabash Ave.
 Cavins, Alexander W. 221 S. Sixth St.
 Combs, Stuart R. 3050 Poplar St.
 Congleton, George C. (S)
 308 Merchants National Bank Bldg.
 Conforti, Victor P. 221 S. Sixth St.
 Conklin, James O. 500 Rose Dispensary Bldg.
 Connerley, Marion L. 501 Tribune Bldg.
 Conway, Thomas J. 221 S. Sixth St.
 Crockett, Wayne A. 416 Rose Dispensary Bldg.

D

Denny, E. Rankin. 3050 Poplar St.
 Drummy, William W. 221 S. Sixth St.
 Dyer, George W. 2235 Wabash Ave.

E

Edwards, Henry G. 6 Rose Dispensary Bldg.
 Eversman, George H., Jr. 670 Cherry St.

F

Freed, John E., Jr. 1030 S. Sixth St.
 Freed, John E. (S) 1030 S. Sixth St.

G

Gerrish, Donald A. R. R. 7
 Gilbert, Ivan. 505 Rose Dispensary Bldg.
 Gillotte, Joseph P. 210 Rose Dispensary Bldg.
 Goodman, Hubert T. 410 Rose Dispensary Bldg.
 Gossom, Donn R. Rose Dispensary Bldg.
 Grindrod, John M. Ind. State Teachers College

H

Harkness, Robert G. 301 Rose Dispensary Bldg.
 Haslem, Ezra R. 401 Rose Dispensary Bldg.
 Haslem, John R. 221 S. Sixth St.
 Hogan, Thomas W. 627 Cherry St.
 Hoover, Dewey A. 1218½ Wabash Ave.
 Humphrey, Paul E. 1235 Ohio Blvd.
 Hunt, Edgar J. R. R. 1

J

Johnson, Paul D. 822 N. Fifteenth St.
 Justin, Renate G. 901 S. 25th St.

K

Kabel, Robert N. 3050 Poplar St.
 Kriebel, William W. 221 S. Sixth St.
 Kunkler, Arnold W. 1700 N. Seventh St.
 Kunkler, Joseph (S) 14 S. Fifth St.
 Kunkler, William C.
 212 Merchants Nat'l Bank Bldg.

X-Y-Z

Zwerner, Paul F.....12 Points State Bank Bldg.
Bristol, Henry M. S.
1627 Atkinson St., Detroit, Mich.

M

Walker, James L. (S).....Lafontaine

N-O

P

R

S

T-U-V

W

WAYNE-UNION COUNTIES

Clark, Marion E.....	Cambridge City
Hill, Paul G.....	Cambridge City
Kenyon, Charles E.....	Cambridge City

Barton, Willoughby M.....Centerville
 Hutchison, Donald R.....Fountain City
 Donahue, Francis E.....Dublin
 Charles, Henry L.....Hagerstown
 Hollenberg, Alfred E.....Hagerstown
 Miller, William A.....Hagerstown

Liberty

Clarkson, Clarence G.....304 E. Union St.
 Lewis, James F.....28 E. Union St.
 McWilliams, William B.....207 N. Market St.

Richmond

Adney, Frank B.....215 Medical Arts Bldg.
 Ake, Loren.....410 First National Bank Bldg.
 Allen, Hubert E. (S).....21 S. Eighth St.
 Allen, Robert T.....34 S. Seventh St.
 Ballenger, William E.....309 Medical Arts Bldg.
 Basso, Rudolph V...P. O. Box 592, Friends Station
 Blossom, Paul W.....825 S. A St.
 Brooks, G. Tanner.....29 S. 12th St.
 Brown, Richard J.....310 Colonial Bldg.
 Buche, Frederick P. (S).....106 S. Seventh St.
 Coble, Frank H.....51 S. Eighth St.
 Cox, Leon T.....1210 E. Main St.
 Daggy, Benjamin T.....Medical Arts Bldg.
 Daggy, James R.....35 S. Eighth St.
 Dingle, Paul E.....216 Medical Arts Bldg.
 Dreyer, Ralph W.....2 S. W. 17th St.
 Ebbinghouse, Tom.....98 W. Main St.
 Griffis, Vierl C. (S).....201 S. 23rd St.
 Guthrie, James R.....1010 S. A St.
 Hadley, Harvey (S).....627 S. 14th St.
 Hagie, Frank E.....1110 S. A St.
 Harmon, Carl J.....407 Medical Arts Bldg.
 Hill, Gladys Marie.....407 Medical Arts Bldg.
 Hill, Harold D.....412 Medical Arts Bldg.
 Hunt, Gayle J.....Reid Memorial Hospital
 Johnson, George M.....136 Medical Arts Bldg.
 Kime, Charles E.....1201 S. A St.
 Klefer, Jefferson F.....Richmond State Hospital
 Kreidl, Dorothy R.....Richmond State Hospital
 Lee, Glen Ward.....139 Medical Arts Bldg.
 Ling, John F.....505 First National Bank Bldg.
 Logan, James Z.....2 N. Eighth St.
 Loomis, Charles H.....1203 S. A St.
 Mader, John H.....2000 E. Main St.
 Malcolm, Russell L.....127 Medical Arts Bldg.
 Meredith, Elwood J.....203 Medical Arts Bldg.
 Miller, Harold L.....603 S. 23rd St.
 Millis, Arthur B.....505 First Nat'l. Bank Bldg.
 Park, Byron J.....418 Medical Arts Bldg.
 Passino, James.....Reid Memorial Hospital
 Pentecost, Paul S.....1300 Chester Blvd.
 Plasterer, Edward D.....212 S. 16th St.
 Porter, George S.....808 S. A St.
 Ramsdell, Glen A.....407 First Nat'l. Bank Bldg.
 Ross, Harry P.....410 Second National Bank Bldg.
 Ross, James S.....1308 N. A St.
 Runge, Paul W.....1426 E. Main St.
 Sage, Charles V.....48 S. 11th St.
 Sherer, Kenneth E.....422 Medical Arts Bldg.
 Shields, Tom.....47 S. 11th St.
 Smith, John R.....617 S. A St.
 Snyder, Morris C.....130 Medical Arts Bldg.
 Stamper, Lucian A.....402 Medical Arts Bldg.
 Stepleton, John D.....Reid Memorial Hospital
 Stillwell, William R.....2607 South C Place
 Sweet, Howard E.....35 S. Eighth St.
 Taylor, William R.....308 Medical Arts Bldg.
 Vance, William C.....1008 South A St.
 Wanninger, Horace...408 Second Nat'l Bank Bldg.
 Warrick, Francis B.....1426 E. Main St.
 Weinstein, Edwin B.....204 Colonial Bldg.
 Weitemier, Raymond A.....2000 E. Main St.
 Wertenberger, Morris D...Reid Memorial Hospital
 Wiland, Olin K.....Reid Memorial Hospital
 Wynegar, David E.....Richmond State Hospital

Zeps, E. Frances.....701 S. 16th St.

Shepard, Fred F.....College Corner, Ohio

WELLS COUNTY**Bluffton**

Bishop, Robert E.....303 S. Main St.
 Boonstra, Charles E.....303 S. Main St.
 Bradley, Louis F.....303 S. Main St.
 Buckner, Joy F.....116 E. Walnut St.
 Caylor, Charles H.....303 S. Main St.
 Caylor, Harold D.....303 S. Main St.
 Caylor, Truman E.....303 S. Main St.
 Collins, Jack T.....303 S. Main St.
 Cook, Robert G.....303 S. Main St.
 Dorrance, Thomas O.....303 S. Main St.
 Eisaman, Jack L.....303 S. Main St.
 Gitlin, Max M.....121 E. Market St.
 Gitlin, William A.....121 E. Market St.
 Hamilton, Orville G.....227 S. Main St.
 Jackson, Charles E.....303 S. Main St.
 Kephart, S. Bruce.....303 S. Main St.
 Lehman, Emery W.....904 S. Bennett St.
 Matzen, Richard N.....303 S. Main St.
 Mead, Clarence H. (S).....227 S. Main St.
 Meier, Donald W.....303 S. Main St.
 Milroy, Robert A.....303 S. Main St.
 Panos, Constantine G.....227 S. Main St.
 Pietz, David G.....303 S. Main St.
 Symon, William E.....303 S. Main St.
 Talbert, Pierre C.....303 S. Main St.
 Yoder, Richard P.....303 S. Main St.

Gingerick, Charles M.....Liberty Center
 Hardin, Wayne E.....Ossian

Rudy, Donald B.
 1906 Adelia Ave., #2, Nashville, Tenn.

WHITE COUNTY

Galbreth, Jesse P. (S).....Burnettsville
 Derhammer, George L.....Brookston
 Gish, Howard M.....Brookston
 Henderson, Robert N.....Brookston
 Netherton, Clyde R. (S).....Chalmers
 Houser, Wayne W.....Monon
 McClure, Stanley E.....Monon

Monticello

Beck, David C.....135 S. Illinois St.
 Carney, John C.....116 N. Illinois St.
 Dickerson, W. Martin.....1114 O'Connor Blvd.
 Fullerton, Robert L.....201 Beach Dr.
 Hibner, Nolan A.....110 S. Main St.
 Morris, Warren V.....115 Court St.

Mayfield, Clifford H. (S).....Reynolds
 Baynes, Frank L.....Wolcott
 Forbes, Violet Crabbe.....Wolcott

WHITLEY COUNTY

Hershey, Ernest A. (S).....Churubusco
 Minick, Linus J.....Churubusco

MEMBERSHIP ROSTER BY COUNTIES

Columbia City

Hamilton, Thomas.....	Columbia City	Reid, Donald B.....	118 E. Van Buren
Heritier, C. Jules.....	116 S. Chauncey	Thompson, Frank M.....	112 N. Main St.
Langohr, John.....	215 E. Van Buren St.	Vogel, John L.....	215 E. Van Buren St.
Lehmberg, Otto F. C.....	118 E. Van Buren St.	Wait, Jerome H.....	115 S. Main St.
Niccum, Warren L.....	215 E. Van Buren St.	Wilson, John	116 S. Chauncey
Nolt, Ernest V. (S)	103 N. Line		
		Huffman, Verlin P.....	South Whitley

WOMAN'S AUXILIARY to the INDIANA STATE MEDICAL ASSOCIATION

OFFICERS: 1961-62

PRESIDENT	Mrs. Burton E. Kintner	3520 E. Jackson Blvd.	Elkhart
PRESIDENT-ELECT	Mrs. Thomas W. Johnson	5735 Washington Blvd.	Indianapolis
IMMEDIATE PAST-PRESIDENT	Mrs. Edward L. Rigley	1704 Ridgedale Road	South Bend
FIRST VICE-PRESIDENT	Mrs. Kenneth Schneider		Nashville
SECOND VICE-PRESIDENT	Mrs. Bernard Hall	3100 E. Broadway	Logansport
THIRD VICE-PRESIDENT	Mrs. Irvin Sonne, Jr.	1607 Hedden Ct.	New Albany
FOURTH VICE-PRESIDENT	Mrs. Harry R. Stimson	4338 Jefferson St.	Gary
RECORDING SECRETARY	Mrs. M. O. Scamahorn		Pittsboro
CORRESPONDING SECRETARY	Mrs. Richard G. Horswell	1629 E. Jackson Blvd.	Elkhart
TREASURER	Mrs. Kenneth Brown	1654 Hedden Park	New Albany
FINANCIAL SECRETARY	Mrs. Marion Wygant	Beatty Memorial Hospital	Westville
HISTORIAN	Mrs. J. Winford Mather	2367 Vigo St.	East Gary
PARLIAMENTARIAN	Mrs. George R. Bowdoin	3809 Greenleaf Blvd.	Elkhart
CHAIRMAN OF DISTRICT COUNCILORS	Mrs. John Carney	Meadow Lawn, R. R. #2	Monticello

COMMITTEE CHAIRMEN

A.M.E.F.	Mrs. William E. Symon	632 S. Main St.	Bluffton
A.M.E.F. TREASURER	Mrs. Donald W. Meier	1205 Summitt Drive	Bluffton
BULLETIN	Mrs. Richard M. Potter	120 W. Walnut	Ridgeville
BY-LAWS	Mrs. Earl W. Bailey	2522 North Street	Logansport
CIVIL DEFENSE	Mrs. Charles Kime	501 South 19th St.	Richmond
COMMUNITY HEALTH	Mrs. Charles Alvey	515 Greenbriar Road	Muncie
EDITORIAL	Mrs. Frank Green	516 N. Morgan St.	Rushville
FINANCE	Mrs. William R. Tindall	616 S. Harrison	Shelbyville
HEALTH CAREERS	Mrs. William Kleifgen	4602 Tacoma	Fort Wayne
LEGISLATION	Mrs. Otis Bowen	304 N. Center St.	Bremen
MEMBERSHIP	Mrs. Kenneth Schneider		Nashville
MENTAL HEALTH	Mrs. Kenneth G. Hill	100 Leland St.	New Castle
ORGANIZATION	Mrs. Thomas W. Johnson	5735 Washington Blvd.	Indianapolis
MEDICAL CARE			
INSURANCE	Mrs. Joseph Black	671 Braewick Rd., Sunset Pkwy.	Seymour
PROGRAM	Mrs. Albert Marshall, Jr.	7802 Allisonville Road	Indianapolis
PUBLICITY	Mrs. Donald J. White	5430 N. Delaware St.	Indianapolis
RURAL HEALTH	Mrs. Robert Seibel		Nashville
SAFETY	Mrs. George W. Wagoner	305 W. Summit St.	Delphi

MEMBERSHIP ROSTER—BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. N. E. 866 Columbia Dr.
Bose, Mrs. Robert L. 255 Dearborn St.
Luginbill, Mrs. Howard. 817 W. Main St.

Decatur

Burk, Mrs. J. M. 221 S. Third St.
Freeby, Mrs. William C. 1022 Mercer Ave.
Girod, Mrs. Arthur H. R.R.
Kohne, Mrs. Gerald J. 304 W. Adams St.
Parrish, Mrs. Richard K. 242 S. 2nd St.
Rich, Mrs. Norval S. R. R. 4
Terveer, Mrs. John B. 1721 W. Monroe St.
Zwick, Mrs. H. F. 401 E. Rugg

Cutshaw, Mrs. James A. Monroeville
Harless, Mrs. Fred O. Monroeville
Schetgen, Mrs. Joseph V. R. R., Geneva

ALLEN COUNTY

Bluffton

Brickley, Mrs. Harry D. 227 S. Main St.
Buckner, Mrs. J. F. 116 E. Walnut
Hamilton, Mrs. O. G. 203 E. Central Dr.
Mead, Mrs. C. H. 211 W. Washington

Fort Wayne

A

Adams, Mrs. E. Wade. 1902 Forest Park Blvd.
Adams, Mrs. J. R. 2538 Fairfield Vw. Pl.
Ahlbrand, Mrs. Roland. 1242 Northlawn
Aiken, Mrs. Arthur F. R. R. #1, Waterswold Dr.
Aiken, Mrs. Nevin E. 5540 Leo Rd.
Arata, Mrs. Justin E. 224 Ludwig Rd.

B

Bailey, Mrs. Paul. 1840 Pemberton
Ball, Mrs. John R. 4112 S. Harrison
Baltes, Mrs. Joseph H. 1309 Sunset Dr.
Barch, Mrs. John W. 1715 Poinsette Dr.
Bash, Mrs. W. E. 1201 Korte Lane
Beams, Mrs. Ralph. 3710 Wawonaissa
Beierlein, Mrs. Karl M. 2716 Butler Road
Bergendahl, Mrs. Emil. 1202 Illsey
Berghoff, Mrs. Raymond. 2009 Forest Park
Beutler, Mrs. Theodore. 3505 S. Washington Rd.
Blichert, Mrs. Peter A. 4501 Fairfield
Blosser, Mrs. H. V. 1122 W. Washington
Bolman, Mrs. R. M. Hamilton Rd.
Borders, Mrs. Theodore R. 1802 Nevada St.
Bossard, Mrs. John W. 1712 California
Bowers, Mrs. G. T. 2609 East Dr.
Brandt, Mrs. William. 1717 Tilden

Bridges, Mrs. W. Lloyd.....207 Southridge Rd.
 Bromley, Mrs. L. W.....4216 Drury Lane
 Brosius, Mrs. Robert H.....3302 Garland
 Brown, Mrs. Frederic W.....4129 S. Harrison
 Brueggeman, Mrs. H. O.....1202 W. Washington
 Bryan, Mrs. Franklin A.....1439 Edgewater
 Buckner, Mrs. Doster.....Bass Rd., R. R. 5
 Buckner, Mrs. George D.....4327 Hampshire Drive

C

Carlo, Mrs. Ernest.....4633 Crestwood
 Cartwright, Mrs. E. L.....3718 Hiawatha Blvd.
 Chambers, Mrs. Alan.....4135 S. Harrison
 Clark, Mrs. Wm. R.....4002 S. Harrison
 Cochran, Mrs. H. A., Jr.....420 W. Sherwood Tr.
 Connelly, Mrs. Richard.....3016 Kingsley
 Cooney, Mrs. Charles C.....1168 Westover Rd.
 Cottrell, Mrs. Robert F.....205 McKinnie
 Craig, Mrs. Richard.....1002 Pasadena
 Culp, Mrs. John E.....2421 Paulding Rd.

D

Datzman, Mrs. Richard.....5402 Bluffton Rd.
 Dunstone, Mrs. H. C.....2433 Paulding Road

E

Eberly, Mrs. Karl C.....1240 W. Rudisill
 Emenhiser, Mrs. John L.....1411 Reed Road

F

Ferguson, Mrs. Arthur N.....328 W. Sherwood
 Flaherty, Mrs. Robert.....1835 Forest Park Blvd.
 Foy, Mrs. H. W.....1816 Forest Park
 Franke, Mrs. Gordon.....4452 Sandridge Dr.
 Frankhouser, Mrs. Chas. M.....7245 Winchester Rd.
 Fullam, Mrs. Richard.....4159 Woodstock

G

Gastineau, Mrs. David C.....8203 Westridge Rd.
 Gerding, Mrs. W. J.....1721 Forest Park Blvd.
 Glassley, Mrs. Stephan.....6950 Stellhorn Rd.
 Glock, Mrs. Maurice E.....1502 Hawthorne Rd.
 Glock, Mrs. Wayne R.....Tonkel Road
 Goebel, Mrs. Carl W.....4102 So. Harrison
 Greenlee, Mrs. Robert L.....3344 Sanibel Dr.
 Griest, Mrs. Walter D.....4809 Arlington
 Griffith, Mrs. H. R.....1913 Forest Park Blvd.

H

Hackett, Mrs. Walter G.....5220 Crandon Lane
 Haffner, Mrs. Herman G.....3606 Mulberry Rd.
 Haley, Mrs. Alvin J.....3720 Stellhorn Rd.
 Haller, Mrs. Richard C.....6333 Bayberry Dr.
 Hamilton, Mrs. Emory D.....2405 Florida Dr.
 Harvey, Mrs. Harry G.....2228 Crescent
 Hasewinkle, Mrs. A. M.....3544 Kirkland Lane
 Hastings, Mrs. Warren C.....1822 Kensington Rd.
 Hattendorf, Mrs. A. Paul.....4041 Old Mill Rd.
 Havens, Mrs. Russell E.....1845 Kensington
 Hershberger, Mrs. Phillip G.....5525 Covington Rd.
 Hickman, Mrs. Donald M.....1815 Kensington Rd.
 Higgins, Mrs. Kenneth E.....3460 Sandpoint Rd.
 Hillary, Mrs. Robert.....6430 Bittersweet Dr.
 Hipkind, Mrs. Richard E.....3929 Wenonah Lane
 Hoffman, Mrs. Arthur F.....3619 Harris Rd.
 Holsinger, Mrs. Robert E.....4617 Indiana
 Howe, Mrs. Fordyce L.....2540 Springfield
 Humphreys, Mrs. John L.....3701 S. Washington Rd.

J

Jackson, Mrs. John F.....4922 Indiana
 Jontz, Mrs. Joseph.....514 Shadyhurst Dr.
 Juergens, Mrs. Richard.....6825 Ludwig Circle
 Jurgenson, Mrs. Walter T.....5009 Indiana

K

Keck, Mrs. Carleton A.....4633 Crestwood
 Kent, Mrs. Richard N.....2717 East Dr.
 Keyes, Mrs. Robert C.....1226 Ilsey Drive
 Kidder, Mrs. O. T.....Lima Rd.
 Kimbrough, Mrs. Robert.....4601 Beaver Ave.
 Kleifgen, Mrs. W. A.....4602 Tacoma
 Klooze, Mrs. Kenneth W.....723 W. Packard
 Knight, Mrs. L. W.....1220 Kensington
 Krueger, Mrs. J. E.....4418 Bradwood Terrace
 Kruse, Mrs. Edward.....4001 Old Mill Rd.
 Kruse, Mrs. Walter E.....1242 Maxine Dr.

L

Ladig, Mrs. Donald S.....2720 Fairfield
 Lampe, Mrs. Elfred H.....1018 Kinnaird
 Land, Mrs. Francis L.....4520 Beaver
 Laycock, Mrs. Richard.....5019 Stellhorn Rd.
 Leming, Mrs. Ben L.....3005 N. Anthony
 Lenk, Mrs. George G.....E. State St. Ext. 5507
 Lloyd, Mrs. Robert P.....3609 S. Anthony
 Lohman, Mrs. Robert M.....2138 Owaissa
 Lorman, Mrs. James G.....3401 Kirkwood
 Loudermilk, Mrs. Jack L.....3032 Glencairn

M

McArdle, Mrs. Edward G.....1133 W. Rudisill Blvd.
 McBride, Mrs. W. O.....610 Beechwood Circle
 McCallister, Mrs. John W.....4215 Drury Lane
 McCoy, Mrs. Roy R.....4101 S. Harrison
 McDowell, Mrs. G. A.....2322 Forest Park Blvd.
 McEachern, Mrs. Cecil.....4242 Old Mill Rd.
 McKeeman, Mrs. D. H.....1615 Ardmore
 Manning, Mrs. George.....4115 Indiana Ave.
 Marshall, Mrs. Caesar L.....1215 McCulloch
 Mastrangelo, Mrs. Michael J.....2718 Priscilla Lane
 Mercer, Mrs. S. R.....3235 W. Washington
 Meyer, Mrs. T. O.....3728 Kirkwood
 Michaelis, Mrs. S. C.....1255 Korte Lane
 Miller, Mrs. Carl G.....457 Oakdale Dr.
 Miller, Mrs. Edward D.....2615 East Drive
 Miller, Mrs. H. Paul.....6408 S. Calhoun
 Miller, Mrs. Mahlon.....1115 Ilsey Dr.
 Miller, Mrs. Orval J.....1810 Kensington
 Miller, Mrs. Richard.....5125 Old Mill Road
 Miller, Mrs. Wm. J.....2620 Capitol
 Moats, Mrs. Carl F.....3210 N. Washington Rd.
 Moeller, Mrs. Victor C.....4723 St. Joe Center Rd.
 Moravec, Mrs. Arthur.....4711 Old Mill Rd.
 Mortenson, Mrs. Leland J.....1310 N. Foster Pkwy.
 Mueller, Mrs. Lawrence W., 3423 S. Washington Rd.
 Murdock, Mrs. Harry L.....1212 Kensington

N-O

Nahrwold, Mrs. E. W.....3314 Irvington Dr.
 Nill, Mrs. John H.....5316 South Wayne
 Nolan, Mrs. Gerald R.....1102 Kensington
 O'Brian, Mrs. John F.....1215 N. Anthony Blvd.
 O'Rourke, Mrs. Carroll.....Covington Road
 Oyer, Mrs. J. H.....2206 Wawonaissa

P

Painter, Mrs. Donald S.....R. R. 1, Southridge Rd.
 Parker, Mrs. C. B.....2215 Paulding Rd.
 Parrot, Mrs. Donald J.....1809 Kensington
 Pearson, Mrs. Huey.....1801 S. Clinton
 Perrin, Mrs. Kermit G.....2828 Lake Ave.
 Perry, Mrs. Frederick F.....1126 Ilsey
 Pickett, Mrs. Merle E.....4509 Atwood Dr.
 Popp, Mrs. Milton F.....3148 Parnell Ave.
 Powell, Mrs. M. Jack.....7412 Ridgeknoll Rd.
 Priddy, Mrs. Marvin.....2909 Belfast Dr.

R

Ranke, Mrs. Henry.....2301 Fairfield
 Rhamy, Mrs. B. W.....4312 Beaver
 Rissing, Mrs. Walter J.....3200 Irvington
 Roser, Mrs. Arthur J.....3559 Leesburg Rd.
 Rossiter, Mrs. D. L.....724 Oakdale Dr.
 Rothberg, Mrs. Maurice.....4319 Hartman Rd.
 Rousseau, Mrs. John W.....3018 Devon

S

Sahlman, Mrs. Hans.....2042 Woodward
 Salon, Mrs. Harry W.....4017 Hiawatha Blvd.
 Salon, Mrs. Joel.....4935 Old Mill Road
 Salon, Mrs. N. L.....7939 Scottwood Court
 Sarver, Mrs. Francis E.....4629 Tacoma
 Savage, Mrs. A. R.....South Ridge Road, R. R. 1
 Schellhouse, Mrs. Earl M.....3610 Mulberry Rd.
 Schlademan, Mrs. K. R.....4029 Weisser Park
 Schloss, Mrs. Robert.....3518 Algonquin Pass
 Schmidt, Mrs. Eugene E.....1119 Maxine Dr.
 Schmoll, Mrs. Robert J.....5214 Woodhurst
 Schneider, Mrs. Louis A.....1351 W. Sherwood Tr.
 Schoen, Mrs. Fred.....5128 S. Wayne
 Scoins, Mrs. W. H.....4301 Taylor
 Scott, Mrs. H. Vaughn.....5224 Fairfield Ave.
 Senseny, Mrs. Eugene F.....3112 Beaver
 Shaw, Mrs. James E.....3932 Rosewood Drive
 Shinabery, Mrs. Lawrence.....1850 Broadway
 Sidell, Mrs. James.....1228 Powers
 Singer, Mrs. Elmer C.....825 W. Oakdale Dr.
 Smith, Mrs. Phillip L.....2701 Fairfield
 Smith, Mrs. Richard B.....709 E. Oakdale
 Smith, Mrs. Roger.....1722 Pemberton
 Snyderman, Mrs. S. C.....3222 N. Washington Rd.
 Somers, Mrs. G. H.....1253 W. Rudisill
 Spencer, Mrs. C. Herbert.....2106 Paulding Road
 Stanley, Mrs. Robert G.....411 W. Concord Lane
 Stauffer, Mrs. Richard.....4120 S. Harrison
 Steigmeyer, Mrs. D. J.....1503 Kensington
 Stellner, Mrs. Howard A.....3323 Butler Court
 Stier, Mrs. Paul.....13120 Ravine Trail, R. R. 6
 Stucky, Mrs. Jerry L.....2524 Belfast Dr.
 Stumpf, Mrs. Edwin E.....1118 Elm St.
 Sullivan, Mrs. Robert E.....4145 Woodstock

T

Taylor, Mrs. Robert G.....3104 Alexander Dr.
 Tennant, Mrs. D. L.....3513 Kirkland Lane
 Terrill, Mrs. Richard.....4727 Old Mill Rd.
 Thompson, Mrs. Holland.....R.R. 1, Carroll Rd.
 Thornton, Mrs. W. E.....601 Oakdale Dr.
 Tomusk, Mrs. August N.....3420 Kirkwood Dr.

U-V

Underwood, Mrs. Ella.....2301 Fairfield
 Van Buskirk, Mrs. Edmund M.....920 Maxine Dr.
 Vogel, Mrs. Lloyd A.....7137 Roseann Pkwy.

W

Wade, Mrs. R. W.....4105 Dalewood Dr., R. R. 9
 Walker, Mrs. Floyd.....1201 Forest Ave.
 Warfield, Mrs. C. H.....3924 Harris Rd.
 Weber, Mrs. John R.....1215 Sheridan Ct.
 Welty, Mrs. S. G.....8416 Stellhorn Road
 Wilkins, Mrs. Robert W.....914 Prange Dr.
 Wilson, Mrs. Leslie.....2810 S. Wayne Ave.
 Wilson, Mrs. Roland B.....4100 Abbott
 Wright, Mrs. William C.....1834 Pemberton Dr.

Z

Zehr, Mrs. Noah.....301 W. Creighton
 Zweig, Mrs. Elmer S.....2001 Pemberton

New Haven

Dahling, Mrs. C. Wallace..Carefree Farms, R. R. 2
 Emenhiser, Mrs. Don C....1040 Lincoln Highway
 Hoetzer, Mrs. Emil M.....Doyle Rd.
 Smith, Mrs. G. A.....2313 Florida

Emme, Mrs. Richard W.....R. R. 2, Grabill
 Mackel, Mrs. Frederick.....R. R. 1, Huntertown
 Harless, Mrs. O. Fred.....Monroeville

BARTHOLOMEW-BROWN COUNTIES

Columbus

Able, Mrs. Walter.....2630 19th St.
 Adler, Mrs. David L.....931 Fifth St.
 Beggs, Mrs. Lowell F.....2733 Riverside Dr.
 Biggs, Mrs. William.....1311 Locust Dr.
 Davis, Mrs. Marvin R.....2300 N. Washington St.
 Daugherty, Mrs. Forest.....2313 31st St.
 Dugan, Mrs. Thomas.....1709 Gilmore St.
 Echsner, Mrs. Herman J.....300 Tipton Lane
 Fisher, Mrs. Walter S.....906 Franklin St.
 Gammell, Mrs. Lloyd.....602 22nd St.
 Hart, Mrs. Robert B.....1203 16th St.
 Hawes, Mrs. Marvin E.....2975 Franklin Dr.
 Henry, Mrs. Alvin L.....1926 Lafayette Avenue
 Jacobs, Mrs. E. Robert.....1629 Franklin St.
 Knotts, Mrs. Stanley.....2740 Washington St.
 Krueger, Mrs. Robert B.....2102 Lafayette Ave.
 Macy, Mrs. George W.....2623 Riverside Dr.
 Marr, Mrs. Griffith.....Marr Rd.
 McCullough, Mrs. Henry.....Old Indianapolis Rd.
 Mohler, Mrs. Floyd.....308 Sunset Dr.
 Norton, Mrs. Harold J.....909 Pearl St.
 O'Bryan, Mrs. Richard B.....1602 Washington St.
 Overshiner, Mrs. Lyman.....1715 Franklin St.
 Ranck, Mrs. B. A.....615 25th St.
 Rau, Mrs. C. A.....2424 Lafayette
 Reid, Mrs. Robert.....2712 Lafayette Avenue
 Richmond, Mrs. Wayne.....2971 Tulip Dr.
 Ryan, Mrs. Wm. J.....3224 Grove Parkway
 Schmitt, Mrs. R. K.....2639 Riverside Dr.
 Sigmund, Mrs. Wm. B.....Davis Road
 Snapp, Mrs. R. A.....1927 Home Ave.
 Weinland, Mrs. George C.....R.R. 5
 Williams, Mrs. E. K.....3020 Washington St.
 Williams, Mrs. E. W.....1902 Franklin St.
 Yoder, Mrs. Dewey D.....713 Lafayette Ave.
 Zaring, Mrs. Byron K.....2419 Riverside Dr.

Knotts, Mrs. Slater.....Elizabethtown
 Dudding, Mrs. Joseph E.....Hope
 Schneider, Mrs. Kenneth.....Nashville
 Seibel, Mrs. Robert.....Nashville

BENTON COUNTY

Leak, Mrs. Robert.....Boswell
 Coddens, Mrs. A. L.....Earl Park
 Miller, Mrs. Dan T.....Fowler
 Turley, Mrs. Verne L.....Fowler
 Scheurich, Mrs. Virgil.....Oxford
 Rutherford, Mrs. C.....Otterbein

BLACKFORD COUNTY

Hartford City

Dodd, Mrs. J. U.....The Oaks
 Dudgeon, Mrs. Charles A.....421 E. North St.
 Jackson, Mrs. Dean D.....401 W. Washington St.
 Owsley, Mrs. Guy A.....The Oaks
 Park, Mrs. George O.....State Rd. 26W
 Weldy, Mrs. Brice P.....227 W. Franklin St.
 Wierzalis, Mrs. Edward.....520 N. Jefferson St.

Burns, Mrs. Paul E.....223 High St., Montpelier
 Douglas, Mrs. William T.....205 E. Monroe St., Montpelier

BOONE COUNTY

Schaaf, Mrs. Alvin D.....Jamestown

Lebanon

Coons, Mrs. John D.....121 Ulen Blvd.
 Coons, Mrs. Ritchie.....138 Ulen Blvd.
 Grigsby, Mrs. Bland.....904 Northfield Drive
 Honan, Mrs. Paul.....202 East Dr.
 Kern, Mrs. Clarence G.....1019 N. Meridian
 Lenox, Mrs. Jack.....203 East Dr.
 Weddle, Mrs. Charles O.....1210 N. East
 Wiseheart, Mrs. Robert H.....123 Ulen Blvd. Dr.

Gregg, Mrs. Edwin.....320 E. Main, Thorntown
 Harvey, Mrs. Ralph.....Zionville
 Lovett, Mrs. Harvey D.....Zionsville

CARROLL COUNTY

Van Kirk, Mrs. John.....Burlington

Delphi

Baker, Mrs. Eldon E.....204 W. Summit St.
 Crampton, Mrs. Chas. C.....218 East Monroe
 Maggart, Mrs. Ralph.....R.R. 3
 Seese, Mrs. Robert M.....201 W. North St.
 Wagoner, Mrs. Geo. W.....305 W. Summit St.

Adams, Mrs. Max R.....Flora
 McLaughlin, Mrs. James R.....Flora

CASS COUNTY

Dutchess, Mrs. Charles T.....Galveston

Logansport

Adamski, Mrs. M. S.....614 17th
 Bailey, Mrs. Earl W.....2522 North
 Ballard, Mrs. Charles A.....R. R. 4, Ballard Rd.
 Bean, Mrs. Joseph S.....R. R. 1
 Burnett, Mrs. Paul C.....Logansport State Hosp.
 Cobb, Mrs. Clarence M.....R. R. 4, Box 8
 Davis, Mrs. John C.....2119 North
 Eckert, Mrs. Russell A.....R. R. 1
 Fitzgerald, Mrs. Brice.....1930 High
 Fogel, Mrs. Ernest J.....Logansport St. Hospital
 Gatzimos, Mrs. Christos D.....3116 High St. Rd.
 Glendening, Mrs. Richard L.....2300 Broadway
 Hall, Mrs. Bernard R.....3100 E. Broadway
 Harrington, Mrs. James F.....2316 Rolling Ridge
 Hedde, Mrs. E. L.....2304 Chase Rd.
 Hillis, Mrs. L. J.....2410 Hoslye Hyll
 Holmes, Mrs. Will W.....2537 East Broadway
 King, Mrs. Jay M.....2319 May Fair Dr.
 Maschmeyer, Mrs. R. H.....Logansport St. Hospital
 Mikan, Mrs. V. Robert.....R. R. 5
 Morrical, Mrs. R. J.....415 Highland
 Schenck, Mrs. Foss.....97 21st St.
 Viney, Mrs. Charles L.....26th and High St.
 Wilson, Mrs. Paul H.....R. R. 5
 Winter, Mrs. Donald K.....R. R. 5

Flanagan, Mrs. E. P.....106 May, Walton
 Lybrook, Mrs. D. E.....Young America
 Ter Bush, Mrs. Edward L.....Twelve Mile

CLARK COUNTY**Charlestown**

Goodman, Mrs. Eli.....802 Market St.
 Jones, Mrs. David.....State Road 39

Clarksville

Mudd, Mrs. Joseph.....103 W. Rosewood Dr.
 Wilner, Mrs. Alan.....214 Rosewood Dr.
 Wolverton, Mrs. George.....115 Rosewood Dr.

Carr, Mrs. Joseph.....Pine Rd., Henryville
 Greene, Mrs. W. R.....Henryville

Jeffersonville

Bizer, Mrs. Mier.....155 Forrest Dr.
 Buckley, Mrs. Ernest.....14 Blanchel Terrace
 Buehler, Mrs. George.....192 Forest Dr.
 Carlberg, Mrs. Dale L.....2 Blanchel Terrace
 Carney, Mrs. J. T.....2602 Hollywood Dr.
 Clark, Mrs. Wm. B., Jr.....Blackston Mill Road
 Dare, Mrs. Lee.....215 Sparks Ave.
 Graham, Mrs. O. P.....713 E. Maple St.
 Havens, Mrs. Alfred Lyle.....203 Sparks Ave.
 Havens, Mrs. Thomas.....400 Chippewa
 Huoni, Mrs. John.....6 Blanchel Terrace Dr.
 Isler, Mrs. Nathaniel.....901 Morningside Dr.
 Reed, Mrs. Edsel.....4 Pawnee Dr.
 Roby, Mrs. A. L.....2708 Hollywood Dr.
 Shaw, Mrs. Houston.....209 Maplewood Dr.
 Thompson, Mrs. Walter.....2021 E. Eighth

Meyer, Mrs. Claude J.
 225 W. Utica St., Sellersburg
 Regan, Mrs. George.....303 Indiana, Sellersburg
 Sturgis, Mrs. Donald G.....542 Linnwood, Sellersburg
 Vandeventer, Mrs. Arthur, 202 Highland, Sellersburg

DEARBORN-OHIO COUNTIES**Aurora**

Baker, Mrs. Leslie M.....204 Fifth
 Frable, Mrs. Frank.....412 Sunnyside Ave.
 Irmischer, Mrs. George.....422 Sunnyside Ave.
 Jackson, Mrs. Kenneth.....Mechanic St.
 Olcott, Mrs. Charles W.....422 Sunnyside
 Treon, Mrs. James F.....505 Fifth St.

McNeeley, Mrs. Matthew J.....Dillsboro

Lawrenceburg

Aldred, Mrs. Allen W.....803 Bode Ave.
 Conrad, Mrs. Henry.....370 Bielby Rd.
 Fagaly, Mrs. William J.....57 Oakley
 Houston, Mrs. Fred D.....533 Ludlow St.
 Hunter, Mrs. Lowell.....370 Bielby Rd.
 Morrison, Mrs. George.....Billups
 Pfeifer, Mrs. James M.....550 Ludlow
 Streck, Mrs. Francis A.....547 Ridge Ave.
 Vail, Mrs. George A.....Ridge Ave.

DECATUR COUNTY

Tremain, Mrs. M. A.....Adams

Greensburg

Acher, Mrs. Robert P.....446 E. Washington
 Callaghan, Mrs. W. C.....R. R. 1, Lincoln Park
 Dickson, Mrs. Dale D.....700 N. East St.
 Miller, Mrs. James C.....178 N. Michigan Ave.
 Morrison, Mrs. J. Trevor.....161 N. Michigan Ave.
 Overpeck, Mrs. Charles.....R. R. 8
 Shaffer, Mrs. William R.....214 N. Franklin
 Walker, Mrs. Louis A.....R. R. 5

Porter, Mrs. Edward.....Westport

DELAWARE COUNTY

Puterbaugh, Mrs. Karl..... Albany
 Hurley, Mrs. John..... Daleville
 Montgomery, Mrs. Lall G.

Box 149A, RFD 1, Gaston

Muncie

A

Adams, Mrs. William B..... W. Jackson St. Pike
 Alvey, Mrs. Charles R..... 515 Greenbriar Rd.
 Anthony, Mrs. Harvey M..... 822 W. Charles

B

Ball, Mrs. Clay A..... 1015 Linden Ave.
 Ball, Mrs. Philip..... 2820 W. Main St.
 Benken, Mrs. Lawrence..... 1511 Riley Rd.
 Bergwall, Mrs. Warren..... 1507 Riley Rd.
 Bibler, Mrs. Henry..... 2625 Parkway Dr.
 Botkin, Mrs. Clyde G..... 2904 Riverside Ave.
 Botkin, Mrs. Thomas..... 2500 Bethel Pike
 Brown, Mrs. Leland..... 605 Waid Ave.
 Brown, Mrs. Stewart D..... R. R. 3, Hamilton Pk.
 Brown, Mrs. Thomas..... Isanogel Road
 Burwell, Mrs. Stanley W..... 3124 Gilbert
 Butterfield, Mrs. Robert..... 222 Winthrop Rd.
 Butz, Mrs. Ralph..... 2920 Godman Ave.

C

Christie, Mrs. Robert..... 321 N. Manning Ave.
 Clauser, Mrs. Eldo H..... 815 Wayne
 Clevenger, Mrs. Joseph H..... 3124 University Ave.
 Cooper, Mrs. John F..... 2820 Glenwood Ave.
 Covalt, Mrs. Wendell E..... 120 Berwyn Rd.
 Cullison, Mrs. John..... 1003 W. Parkway Dr.
 Cure, Mrs. Elmer T..... 913 University Ave.

D

Deutsch, Mrs. Wm..... 2100 Petty Rd.
 Dunn, Mrs. Farrell W..... 1417 Wheeling Ave.
 Dunning, Mrs. Thomas..... 3 Briar Rd.

E-F

Eissman, Mrs. Eugene..... 211 Alden Rd.
 Funk, Mrs. John..... 3700 Peachtree Lane

G

Garling, Mrs. L. C..... 37 Briar Rd.
 Geckler, Mrs. Charles E..... 1007 W. North St.
 Gibson, Mrs. Robert..... 306 Taft Rd.
 Gill, Mrs. Tom..... 45 Warwick Rd.
 Greiber, Mrs. Marvin..... 310 Riley Rd.
 Gustafson, Mrs. Milton H..... 230 Stradling Rd.

H-I

Hall, Mrs. O. A..... 2302 Lanewood
 Hall, Mrs. Robert..... 701 Brentwood
 Hammond, Mrs. Keith..... 2112 Petty Rd.
 Hayes, Mrs. T. R..... 19 Warwick Road
 Henderson, Mrs. Ramon..... 75 Warwick Rd.
 High, Mrs. Ralph..... 2825 University Ave.
 Hill, Mrs. Howard..... 106 Berwyn Rd.
 Holmes, Mrs. John..... 908 W. Gilbert
 Hostetter, Mrs. I. S..... 300 Winthrop Rd.
 Hurley, Mrs. Anson..... 1021 E. Parkway Dr.
 Imhof, Mrs. J. D..... 46 Warwick Rd.

K-L

Kammer, Mrs. Walter F..... 1005 W. Parkway Dr.
 Kirshman, Mrs. F. E..... 41 Briar Rd.
 Ko, Mrs. Richard..... R. R. 7
 Koss, Mrs. Wm. K..... 1504 Winthrop Rd.

M-N

Mathewson, Mrs. R. C..... Benton Rd.
 McClellan, Mrs. John..... 206 McKenzie Rd.
 McClintock, Mrs. James A... 3121 University Ave.
 McCoy, Mrs. George..... 516 Waid Ave.
 McDowell, Mrs. Fletcher W..... 1721 N. Tillotson
 Moore, Mrs. Tom C..... 1011 E. Parkway Dr.
 Morris, Mrs. J. W..... 222 Stradling Rd.
 Moss, Mrs. M. J..... 1010 W. Parkway Dr.
 Nelson, Mrs. Harold E..... 3216 Torquay Rd.

O

Owens, Mrs. Richard R..... 3011 Oaklyn Ave.
 Owens, Mrs. Thomas..... 608 E. Charles

P-Q

Peacock, Mrs. Robert..... R. R. 3
 Pippinger, Mrs. Joseph..... 1912 Surrey Dr.
 Pippinger, Mrs. W. G..... 1200 N. Tillotson
 Quick, Mrs. Wm..... Moore Rd.

R

Rettig, Mrs. Arthur..... 614 N. McKinley Ave.
 Rivers, Mrs. Glynn..... 307 Alden Rd.

S

Schulhof, Mrs. M. G..... 921 W. Parkway Dr.
 Smith, Mrs. J. S..... 1006 E. First St.
 Speck, Mrs. Carlson..... 1205 Brentwood
 Steele, Mrs. F. M..... 421 Bittersweet
 Stibbins, Mrs. Warren E..... 2908 Torquay Rd.
 Stout, Mrs. Francis E..... 102 Berwyn Rd.
 Stump, Mrs. Richard..... 1304 Bethel

T

Taylor, Mrs. Donald..... 8 Wildwood Lane
 Taylor, Mrs. James A..... 1613 Riley Rd.
 Tomlin, Mrs. Hugh M..... 2920 Beechwood Ave.

V-W

Voss, Mrs. Gert..... 2512 Petty Rd.
 Walker, Mrs. Jack..... R. R. 6, Box 385A
 Ware, Mrs. Herbert..... 1700 Glen Ellyn

Y

Young, Mrs. G. S..... 114 Berwyn Rd.

Hinchman, Mrs. Jean..... Parker
 Hill, Mrs. Robert..... Yorktown
 Moore, Mrs. Will C... White Oak Farm, Yorktown
 Rutledge, Mrs. Jean..... R. R. #1, Yorktown

DUBOIS COUNTY

Barrow, Mrs. John..... Dale, P. O. Box 128
 Backer, Mrs. Henry George.. Ohio St., Ferdinand

Huntingburg

Amini, Mrs. Sohrab..... R. F. D. #2
 Bretz, Mrs. John..... Orchard Road
 Heaton, Mrs. Elton..... Cedar Heights
 Scales, Mrs. Alfred B..... R. R. 2
 Scales, Mrs. Allen..... Cedar Heights
 Steinkamp, Mrs. Emil..... 302 Walnut
 Stork, Mrs. Harvey K..... 523 First St.
 Williams, Mrs. Fielding..... 511 Geiger St.

Jasper

Bevan, Mrs. John..... R. R. 2
 Casper, Mrs. Joseph..... 205½ West 7th St.
 Gootee, Mrs. Francis..... Jasper
 Gootee, Mrs. Thomas..... Dorbett Street

Heck, Mrs. Martin C. 408 W. 15th
 Held, Mrs. George A. 716 W. Ninth
 Klammer, Mrs. Charles H. 616 W. 13th St.
 Ploetner, Mrs. Edward Dorbett Street
 Salb, Mrs. J. P. R. R. #5
 Wagner, Mrs. Arthur R. R. 5, Box 188

ELKHART COUNTY

Bristol

Neidballa, Mrs. E. G. R. R. 1
 Patrick, Mrs. Glen P. R. F. D. 1
 Schlosser, Mrs. H. C. Seven Gables, W. Vistula St.

Elkhart

Atwood, Mrs. Wm. H., Jr. 520 Cedar St.
 Bender, Mrs. R. L. 125 N. Riverside Dr.
 Benson, Mrs. James E. 1501 Fulton St.
 Billings, Mrs. Elmer R. 2022 E. Jackson Blvd.
 Bloom, Mrs. George R. 1100 E. Jackson Blvd.
 Boling, Mrs. Richard C. 407 Village Lane
 Bowdoin, Mrs. George E. 3809 Greenleaf Blvd.
 Campbell, Mrs. Patrick B. 1618 Cone St.
 Classen, Mrs. Pete R. C. 635 W. Wolf Ave.
 Compton, Mrs. Walter A. 2225 Greenleaf Blvd.
 Conklin, Mrs. R. L. 215 Swanson Circle West
 Cormican, Mrs. Herbert L. 2002 E. Jackson Blvd.
 Crandall, Mrs. L. A., Jr. 3600 W. Indiana Ave.
 Dovey, Mrs. E. G., Jr. 1430 Ervin St.
 Echeverria, Mrs. Rodolfo E. 1127 Strong
 Elliott, Mrs. Thomas A. 2001 Stevens Ave.
 Finfrook, Mrs. James D. 811 Laurel St.
 Fleming, Mrs. Claude F. 229 W. Jackson Blvd.
 Futterknecht, Mrs. James C. 2313 Morehouse Ave.
 Gattman, Mrs. G. Beach. 1319 Lawn Ave.
 Hannah, Mrs. Jack W. 1906 E. Jackson Blvd.
 Hemingway, Mrs. Norman L. 1700 Rainbow Bend Blvd.

Horswell, Mrs. R. G. 1629 E. Jackson Blvd.
 Hull, Mrs. A. W. 3333 Greenleaf Blvd.
 Hurley, Mrs. James William. 1705 Roys Ave.
 Ivy, Mrs. John H. 1311 Kilbourn St.
 Jones, Mrs. Robert B. 1833 Rainbow Bend Blvd.
 Keating, Mrs. John U. 1416 Strong Ave.
 Kesim, Mrs. Musit Husam. 903 W. Franklin Ave.
 Kintner, Mrs. Burton E. 3520 E. Jackson Blvd.
 Kistner, Mrs. Arthur W. R. F. D. 3, Box 81
 Koehler, Mrs. Elmer George. 615 N. Riverside Dr.
 Krause, Mrs. Frederick. 1001 St. Clair St.
 Leasure, Mrs. Kenneth E. 1128 Kenmore Ave.
 Lundt, Mrs. Milo O. 519 S. Second St.
 Martin, Mrs. Floyd S. 2301 S. Main St.
 Martin, Mrs. Paul H. 1519 Strong Ave.
 McArt, Mrs. Bruce A. 905 Strong Ave.
 Mendez, Mrs. Carlos. 1109 Baker Dr.
 Miller, Mrs. Galen R. 2229 Thorndale Ct.
 Miller, Mrs. Hugh A., Jr. 417 Prospect St.
 Miller, Mrs. Samuel T. 174 Witmer Ave.
 Mininger, Mrs. Edward P. 1118 E. Jackson Blvd.
 Mishkin, Mrs. Irving. 1809 Rainbow Bend Blvd.
 Paff, Mrs. Wm. A. 1745 Rainbow Bend Blvd.
 Paine, Mrs. George E. 329 Meisner Ave.
 Pancost, Mrs. Vernon K. 160 Riverview Ave.
 Parshall, Mrs. Dale B. 3538 Gordon Rd.
 Rouen, Mrs. Robert L. 1919 E. Jackson Blvd.
 Rupe, Mrs. L. O. R. R. #4, Oakland Ave. Rd.
 Sears, Mrs. M. Maywood. 4806 W. Indiana Ave.
 Slabaugh, Mrs. Jancy S. 258 N. Main St.
 Sobel, Mrs. Z. W. 433 East Blvd.
 Spray, Mrs. Page E. 658 Kilbourn St.
 Stubbins, Mrs. William. 15 St. Joseph Manor
 Swihart, Mrs. Danny D. 1219 Greenleaf Blvd.
 Swihart, Mrs. Homer R. 1621 E. Jackson Blvd.
 Swihart, Mrs. Leonard F. 3213 Calumet Ave.
 Wilson, Mrs. O. E. 2505 Greenleaf Blvd.
 Work, Mrs. James A., Jr. 4 St. Joseph Manor
 Yoder, Mrs. C. Richard. 409 Prospect St.

Goshen

Bender, Mrs. C. K. 624 S. Fifth St.
 Bowser, Mrs. Herschel P. 203 S. 6th St.
 Bowser, Mrs. Philip G. 707 S. 7th St.
 Chandler, Mrs. L. H. 412 S. Fifth St.
 Freeman, Mrs. F. M. 309 E. Washington St.
 Graber, Mrs. Virgil R. R. R. #2
 Harris, Mrs. Ralph V. 307 S. 7th St.
 Hostetler, Mrs. C. M. 1602 S. Eighth St.
 Kennedy, Mrs. Myron S. 414 S. 7th St.
 Krabill, Mrs. Willard S. 420 Westwood Rd.
 Nelson, Mrs. D. Chester. 1210 S. Eighth St.
 Quilty, Mrs. Thomas J. 801 S. 7th St.
 Troyer, Mrs. Dana O. 1727 South 13th St.
 Troyer, Mrs. George W. 1204 S. 8th St.
 Turner, Mrs. John P. 507 Greene Road
 Vander Bogart, Mrs. Harry E. 1411 S. Eighth St.
 Wagner, Mrs. D. G. 307 S. Seventh St.
 Westfall, Mrs. George S. 2422 S. Main St.
 Yoder, Mrs. Albert C. 816 S. Sixth St.
 Yoder, Mrs. Jonathan G. 1204 S. Eighth St.

Nappanee

Fleetwood, Mrs. R. A. 555 N. Nappanee St.
 Kendall, Mrs. F. M. 654 Woodland
 Price, Mrs. Douglas W. 607 E. Van Buren

DeFries, Mrs. John J. New Paris
 Clark, Mrs. Jack P. R. R., Syracuse
 Fosbrink, Mrs. E. L. 218 S. Huntington, Box 157,
 Syracuse
 Zimmerman, Mrs. William H. R. R. 2, Syracuse
 Massanari, Mrs. Walter S. Millersburg
 Miller, Mrs. Donald G. 105 Brown St., Middlebury
 Rheinheimer, Mrs. Floyd L. Box 142, Milford

Wakarusa

Abel, Mrs. Robert. 105 E. Harrison
 Guttman, Mrs. John B. 201 N. Elkhart Ave.
 Ganser, Mrs. Ralph V. 1035 Lincolnway East,
 Mishawaka
 Zeitler, Mrs. Philip S. 2838 Rockne Dr., So. Bend

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Mrs. Walter A. 617 Main
 Smith, Mrs. H. N. 812 Main
 Seal, Mrs. Perry F. 901 Main

Connersville

Ashworth, Mrs. Louis Neff. 2027 Indiana Ave.
 Brookman, Mrs. Robert E. 2750 Grand Ave.
 Clark, Mrs. Helen Nevin. 303 Western Ave.
 Ellis, Mrs. George M. 108 East 10th St.
 Gregg, Mrs. Albert F. 835 Lincoln Ave.
 Hudson, Mrs. Arlington M. 80 East Drive
 Kauffman, Mrs. Robert W. R. F. D. 2
 Kemp, Mrs. W. Alfred. 403 W. 28th St.
 Lockhart, Mrs. Jack M. 54 West Drive
 Morrow, Mrs. Roy D. 629½ Eastern Ave.
 Mountain, Mrs. Francis B. 1720 Virginia Ave.
 Sanders, Mrs. Bertram W. 1533 Virginia Ave.
 Steinem, Mrs. Joseph L. R. F. D. #3
 Watterson, Mrs. Gerald T. 1704 Virginia Ave.
 Winklepleck, Mrs. A. M. R. F. D. 6

Poston, Mrs. C. L. R. R. 2, Laurel

FLOYD COUNTY

Jeffersonville

Baxter, Mrs. S. M. 3100 Centralia Ct.
 Gentile, Mrs. John P. 3405 Centralia Ct.
 McCullough, Mrs. J. Y. 3500 Centralia Ct.
 Sloan, Mrs. Herbert. 213 Lynnwood,
 Lincoln Heights

Ambrose, Mrs. J. C.....298 N. Ninth
Campbell, Mrs. Sam.....R. R. 1
Hash, Mrs. J. S.....R. R. 4
Haywood, Mrs. John.....1260 Lincoln Dr.
Kraft, Mrs. Haldon.....R. R. #5

Lanning, Mrs. R. Adrian.....R. R. 3
 Lloyd, Mrs. Joe.....559 Sunset Dr.
 Shanks, Mrs. Ray.....R. R. 5
 Shonk, Mrs. H. W.....408 North Ninth St.
 Smith, Mrs. Charles.....23 N. 10th

Newby, Mrs. Eugene.....Sheridan
 Waitt, Mrs. Paul.....Sheridan
 Connoy, Mrs. Andrew.....Westfield
 Connoy, Mrs. Leo.....139 N. Union St., Westfield

HANCOCK COUNTY

Johnston, Mrs. W. R.....Charlottesville
 Naven, Mrs. Hugh K.....Fortville
 Rhynearnson, Mrs. H. R....235 Merrill St., Fortville

Greenfield

Beeson, Mrs. Wilbur.....209 N. Penn.
 Farrell, Mrs. John J., Jr....304 W. McKenzie Rd.
 Gill, Mrs. D. D.....328 Park St.
 Kinneman, Mrs. R. E.....McClelland Dr.
 Kirby, Mrs. Ted C.....122 Grandison Rd.
 Smith, Mrs. John H.....919 Maple Dr.
 Vingis, Mrs. Bronie A.....705 N. State
 Woods, Mrs. J. R.....715 N. East St.

Cagle, Mrs. Robert.....New Palestine
 Miller, Mrs. Joseph A.....R. R. 12, Box 230 Y,

Oaklandon
 Kuhn, Mrs. Robert.....Wilkinson
 Freeborn, Mrs. Warren.....Oaklandon

HENDRICKS COUNTY

Black, Mrs. James.....702 E. Main, Brownsburg
 Foltz, Mrs. Lloyd.....6 Greenacre Dr., Brownsburg
 Scudder, Mrs. A. N.....Brownsburg

Danville

Koch, Mrs. Elmer.....301 S. Bowen
 Kirtley, Mrs. Robert W.....R. R. 3, Box 196
 Terry, Mrs. Lloyd.....292 W. Marion

Ellis, Mrs. L. Hall.....Lizton
 Scamahorn, Mrs. Malcolm.....Pittsboro

Plainfield

Aiken, Mrs. Milo M.....140 N. Center
 Cohen, Mrs. Irvin.....645 E. Main St.
 Haggard, Mrs. David B.....R. R. 2, Box 23a
 Stafford, Mrs. J. C.....223 Avon Ave.
 Stafford, Mrs. William C.....625 S. East St.
 Warbinton, Mrs. Fred.....R. R. 2

HENRY COUNTY

New Castle

Amos, Mrs. Robert L.....924 Lincoln Ave.
 Balcom, Mrs. Francis.....2003 Wuthering Dr.
 Bledsoe, Mrs. James.....319 South 14th
 Burnett, Mrs. Arthur B.....801 Melody Lane
 Craig, Mrs. Alex F.....415 Raintree Dr.
 Davies, Mrs. Robert R.....1125 Audubon Rd.
 Fisher, Mrs. John Edward...1135 Woodlawn Dr.
 Foster, Mrs. Ray T.....420 N. Main
 Harrison, Mrs. Benjamin L.....233 Bundy Ave.
 Heilman, Mrs. William C.....1111 Audubon Rd.
 Heilman, Mrs. William C. Jr..1112 St. James Ct.
 Hill, Mrs. Kenneth C.....100 Leland St.
 Itermann, Mrs. George.....729 I St.
 Kennedy, Mrs. W. U.....701 S. 14th St.
 Life, Mrs. Homer L.....1101 St. James Dr.
 McDonald, Mrs. Frank G.....527 S. Main St.
 McElroy, Mrs. James S.....1213 Audubon Rd.
 McKee, Mrs. Roy.....Parkplace
 Murray, Mrs. William.....100 Van Nuyes Rd.
 Saint, Mrs. William.....705 Hawthorn Rd.
 Smith, Mrs. Mark.....631 S. 11th St.

Steussey, Mrs. Calvin.....601 Hosier Dr.
 Stout, Mrs. Walter M.....1103 Audubon Rd.
 Strickler, Mrs. Paul J.....719 Fair Oaks Dr.
 Thorne, Mrs. Charles E.....1225 Audubon Rd.
 Vivian, Mrs. Donald E.....2715 Fair Oaks Dr.

Charles, Mrs. Henry.....Hagerstown
 Hollenberg, Mrs. A. E.....105 N. Franklin St., Hagerstwn

Kenyon, Mrs. Emil.....303 Mulberry St., Cambridge City
 Lloyd, Mrs. Marshall.....Walnut, Mt. Summit
 Robertson, Mrs. William.....Spiceland
 Stauffer, Mrs. George E.....Mooreland
 Wiatt, Mrs. Leonard.....108 N. Washington St., Knightstown

HOWARD COUNTY

Denton, Mrs. Larkin.....S. Meridian, Greentown
 Shoup, Mrs. E. M.....N. Meridian, Greentown

Kokomo

Adams, Mrs. C. J.....1216 W. Superior
 Alward, Mrs. J. H.....401 W. Walnut
 Artis, Mrs. Myrle E.....910 E. Broadway
 Ault, Mrs. C. H.....3015 Dellwood Drive
 Behn, Mrs. Walter.....1208 Highland
 Boughman, Mrs. J. D.....1515 W. Jefferson
 Bowers, Mrs. C. C.....1530 W. Taylor
 Bowers, Mrs. Garvey B.....421 Morningside
 Bowers, Mrs. J. A.....1535 W. Jefferson
 Brown, Mrs. Earl R., Jr.....1414 Kingston Rd.
 Bruegge, Mrs. Theodore J.....2225 S. Wabash
 Cattell, Mrs. Lee M.....R. R. #1
 Clarke, Mrs. Elton R.....1400 W. Sycamore
 Conley, Mrs. T. M.....2811 Dellwood Dr.
 Craig, Mrs. R. A.....West Sycamore Rd.
 Craig, Mrs. Ruben.....R. R. 1
 Cuthbert, Mrs. F. S.....1027 W. Walnut
 Earl, Mrs. M. M.....1735 W. Walnut
 Ferry, Mrs. P. J.....1207 W. Sycamore
 Fields, Mrs. Donald L.....3021 Mayfair
 Frazier, Mrs. Jack L.....2318 S. Wabash
 Fretz, Mrs. Richard C.....145 Westmorland Dr.
 Golper, Mrs. M. N.....411 Morningside Drive
 Good, Mrs. R. P.....227 N. Forest Dr.
 Grothouse, Mrs. Carl B.....515 Rainbow Dr.
 Halfast, Mrs. Richard W.....2505 Katherine Ave.
 Hoyt, Mrs. John M.....1017 S. Delphos
 Hutto, Miss Arvilla.....1020 W. Walnut
 Hutto, Mrs. O. D.....1020 W. Walnut
 Hutto, Mrs. William H.....West Sycamore Rd.
 Jewell, Mrs. G. M.....1318 W. Sycamore
 Kremers, Mrs. George A.....2401 S. Wabash
 Martin, Mrs. Will J.....409 W. Sycamore
 McClure, Mrs. Warren N.....309 Lody Lane
 McIndoo, Mrs. R. E.....820 W. Walnut
 Mendelson, Mrs. Stanley M.....2325 S. Wabash
 Michael, Mrs. Robert L.....West Sycamore Rd.
 Morrison, Mrs. W. R.....413 Conradt Ave.
 Murray, Mrs. E. C.....2200 S. Webster
 Paris, Mrs. Durward W.....2417 S. LaFountain
 Perkins, Mrs. John L.....2425 S. Washington
 Phares, Mrs. Robert W.....R. R. 1, Box 31A
 Prather, Mrs. P. E.....123 Magnolia Dr.
 Rudicel, Mrs. M. W.....1604 Kingston Rd.
 Schwartz, Mrs. F. C.....West Sycamore Rd.
 Shenk, Mrs. E. M.....306 N. Webster
 Smith, Mrs. G. J.....821 E. Dixon St.
 Sorenson, Mrs. Raymond.....R. R. 1
 Spangler, Mrs. J. S.....2126 S. Webster
 Wachob, Mrs. Tom W., Jr.....806 James Dr.
 Wible, Mrs. James H.....R. R. #2, W. Jefferson Rd.

Evans, Mrs. Robert.....Russiaville
 Ware, Mrs. John R.....Russiaville
 Tranter, Mrs. William F.....Sharpssville

HUNTINGTON COUNTY**Huntington**

Brubaker, Mrs. Harold S. 721 Flaxmill Rd.
 Casey, Mrs. Stanley M. 408 E. Market St.
 Cope, Mrs. Stanton E. 1022 N. Jefferson St.
 Erehart, Mrs. Mark G. Maple Grove Rd.
 Eviston, Mrs. J. Boyd. 1392 Poplar St.
 Grayston, Mrs. Wallace S. 303 E. Market St.
 James, Mrs. Thomas, Jr. 1044 Poplar St.
 Johnston, Mrs. Robert G. 339 E. Market St.
 Marks, Mrs. Howard H. 1120 N. Jefferson
 Meiser, Mrs. Robert D. 1738 Cherry St.
 Mitman, Mrs. Floyd B. 1470 Poplar St.
 Omstead, Mrs. Trevalyn W. 231 Vine Street
 Van Campen, Mrs. Warren. 354 E. Washington
 Wagner, Mrs. Richard. R. R. 8

Woods, Mrs. Halden C. Markle
 Cooper, Mrs. B. Trent. Roanoke
 Bennett, Mrs. J. B. Warren
 Ray, Mrs. Carl S. Warren
 Gray, Mrs. Paul M. P. O. Box 344

JACKSON-JENNINGS COUNTIES**Brownstown**

Gillespie, Mrs. G. R. 701 Commerce
 Shields, Mrs. Jack. 721 W. Spring
 Scharbrough, Mrs. William. Brownstown

Crothersville

Adair, Mrs. W. K. 208 S. Armstrong
 Bard, Mrs. Frank B. 305 E. Howard
 Rothring, Mrs. Howard. R. R. 2

North Vernon

Berkshire, Mrs. Shaffer. 130 Long St.
 Calli, Mrs. Louis J. 408 S. State
 Ellis, Mrs. Forrest D. 110 W. Long St.
 Green, Mrs. John. Elm St.
 Johnson, Mrs. William J. 318 Jennings St.
 Matthews, Mrs. Dennis W. Walnut St.
 Thayer, Mrs. Benet W. 214 Jennings St.

Seymour

Baxter, Mrs. Harry. 710 West Dr., Sunset Pkwy.
 Black, Mrs. J. M. 671 Braewick Rd., Sunset Pkwy.
 Bobb, Mrs. Kenneth E. 311 Lee Blvd.
 Bosch, Mrs. Ralph O. 930 South Dr., Sunset Pkwy.
 Day, Mrs. Durbin. 515 W. Sixth St.
 Graessle, Mrs. H. P. 640 East Dr., Sunset Pkwy.
 Kamman, Miss Martha. 332 W. Oak St.
 Martin, Mrs. Guy. 1408 Ewing Rd.
 Osterman, Mrs. L. H. 901 Garden Ave.
 Ripley, Mrs. John W. 2001 Ewing St.
 Shortridge, Mrs. Wilbur H. 314 Kessler Blvd.
 Templeton, Mrs. Ian. 348 Carter Blvd.
 Wiethoff, Mrs. C. A. 615 West Dr., Sunset Pkwy.

Hingeley, Mrs. John

Muscatatuck St. School, Butlerville

Jolly, Mrs. Donald

Muscatatuck St. School, Butlerville

JASPER-NEWTON COUNTIES

Schantz, Mrs. Richard. Remington
 Schoonveld, Mrs. Arthur. Brook
 Yegerlehner, Mrs. R. S. Kentland
 Parker, Mrs. John. Goodland
 Brady, Mrs. Kingdon. Morocco

Rensselaer

Beaver, Mrs. Raymond E. 111 Thompson St.
 Greene, Mrs. Robert W. 732 Elza St.
 Jones, Mrs. Edwin F. 617 Dean Place
 O'Brien, Mrs. Francis E. 530 Park Ave.
 Ockermann, Mrs. Kenneth R. 202 Home St.
 Williams, Mrs. Paul A. 402 N. Weston St.

JAY COUNTY

Girod, Mrs. Donald A. 106 Moore Ave., Dunkirk
 Heller, Mrs. N. L. Dunkirk

Portland

Badders, Mrs. Ara C. 709 W. North
 Cripe, Mrs. Wm. H. 507 W. High
 Cronin, Mrs. H. Joseph. 828 E. Water
 Fitzpatrick, Mrs. James S. 405 W. Race
 Gillum, Mrs. Eugene. W. Votaw Street
 Keeling, Mrs. F. E. 609 W. Race
 Morrison, Mrs. George G. R. R. #4
 Schenck, Mrs. Ralph. W. Seventh
 Spahr, Mrs. Donald E. 615 W. Race
 Steffy, Mrs. Ralph M. 321 E. Race

JEFFERSON-SWITZERLAND COUNTIES**Madison**

Alcorn, Mrs. Merritt O., Jr. R. R. 2
 Childs, Mrs. Wallace Edward. 414 N. Broadway
 Fong, Mrs. Theodore C. C. Madison St. Hospital
 Gambill, Mrs. John R. Madison State Hospital
 Hare, Mrs. Frank W. 705 W. 2nd Street
 May, Mrs. George Arthur. 226 Maywood Lane
 McAtee, Mrs. Ott B. Madison State Hospital
 Pratt, Mrs. Ralph M., Jr. 2325 Blackmore St.
 Shuck, Mrs. Wm. A. R. F. D. 1
 Sloan, Mrs. Keith W. 340 Bunton Lane
 Whitsitt, Mrs. Schuyler A. 718 W. Main St.
 Zink, Mrs. Robert Otto. 502 Broadway

JOHNSON COUNTY

Hibbs, Mrs. W. G. R. F. D. 1, Whiteland
 Earnhart, Mrs. Harlan. 612 N. Park, Edinburg
 Elleman, Mrs. John H. 431 W. Park Dr.

Franklin

Andrews, Mrs. Hugh K. 1138 Orchard Lane
 Bullers, Mrs. Robert C. 551 Center St.
 Bullington, Mrs. George. R. F. D. #4
 Chappel, Mrs. A. T. 174 Center Court
 Deppe, Mrs. Charles F. 1215 Park Ave.
 Ferrara, Mrs. Joseph F. 1000 E. King St.
 Foster, Mrs. R. H. K. 1025 Orchard Lane
 Jones, Mrs. Charles A. 1010 E. Adams Dr.
 Mock, Mrs. Harry E. 201 E. Monroe St.
 Murphy, Mrs. Harry E. 150 N. Main St.
 Portteus, Mrs. Walter L. R. R. 2, Box 11-B
 Province, Mrs. Wm. D. 51 N. Water St.
 Records, Mrs. Arthur W. 216 E. Jefferson St.
 Ritteman, Mrs. George. R. R. 3, Box 19A
 Stogsdill, Mrs. W. W. R. R. #4
 Walters, Mrs. Jack L. 1205 E. Jefferson St.

Greenwood

Brown, Mrs. George E. Beech Park Dr.
 Fox, Mrs. Richard. 110 Roselane
 Kunz, Mrs. Albert. 510 Howard Rd.
 Onyett, Mrs. Harold. R. R. 4, Box 125
 Sheek, Mrs. Kenneth L. 407 S. Forest Dr.
 Snodgrass, Mrs. Robert. 360 S. Madison
 Tiley, Mrs. George. 40 N. Madison
 Young, Mrs. Joseph W. 400 N. Madison St.

KNOX COUNTY

Shanklin, Mrs. Jack L. Bicknell

Vincennes

Anderson, Mrs. John. 1202 Busseron St.
 Barrett, Mrs. Thomas L. 2520 Old Orchard Rd.
 Bartlett, Mrs. Donald T. 429 S. 6th St.
 Black, Mrs. Boyd K. State Road 67 - N
 Cantwell, Mrs. Edgar R. Vincennes
 Chattin, Mrs. Herbert O. 729 Main
 Coffel, Mrs. Melvin H. Simpson Lake

Correntino, Mrs. Bart.....110 State Rd. 67
 Curtner, Mrs. Myron L.....216 N. Sixth
 Edwards, Mrs. Edward T., Jr....Old Bruceville Rd.
 Ewing, Mrs. Nathaniel D.....Monroe City Rd.
 Green, Mrs. Carl L.....R.R. #1
 Hendrix, Mrs. Charles.....1202 E. Sycamore
 Humphreys, Mrs. Joe S.....1602 Weed Lane
 McCormick, Mrs. Hubert D.....518 N. Fourth
 McMahan, Mrs. V. C.....Monroe City Rd.
 Nichols, Mrs. Robert J.....1515 Burnett Lane
 Shaffer, Mrs. Kenneth.....2600 Ridge Rd.
 Smith, Mrs. S. Joseph.....504 N. Fourth Street
 Spencer, Mrs. Frederic.....902 Perry Street
 Stein, Mrs. Richard A.....1304 E. St. Clair
 Stewart, Mrs. Frank W.....Hillcrest Rd.
 Sullenger, Mrs. A. A.....803 Seminary St.
 Vaughn, Mrs. Walter R.....406 N. Third
 Welch, Mrs. Norbert M.....Monroe City Rd.

KOSCIUSKO COUNTY

Baum, Mrs. John R.....307 7th St., Winona Lake
 Hursey, Mrs. Virgil G.....Milford
 Pierson, Mrs. Pearl H.....R. R. 1, Silver Lake
 Urschel, Mrs. Dan L.....Mentone
 Wilson, Mrs. Wymond B...P. O. Box 421, Mentone

Warsaw

Arford, Mrs. John E.....104 Argonne Rd.
 Cron, Mrs. William.....R. R. 2
 Doremire, Mrs. Robert D.....R. R. 2
 Hashemi, Mrs. Hossein.....1306 Ranch Rd.
 Haymond, Mrs. George M.....Country Club Rd.
 Hillery, Mrs. John L.....823 E. Center
 Johnson, Mrs. John J.....R. R. 2
 Laird, Mrs. L. A.....322 S. Indiana
 Murphy, Mrs. Samuel C.....216 South High St.
 Richer, Mrs. Orville.....914 E. Main St.
 Schlemmer, Mrs. George H.....528 N. Lake St.
 Shrader, Mrs. Carl.....Spring Hill Acres
 Thomas, Mrs. E. Winton.....711 E. Main St.

LAKE COUNTY

Cedar Lake

Miller, Mrs. D. C.....P. O. Box 297
 Misch, Mrs. W. A.....R. R. 4, Box 58

Crown Point

Gutierrez, Mrs. P. E.....729 Williams Dr.
 Horst, Mrs. W. N.....R. R. 7, Box 151
 Ramos, Mrs. A. F.....551 Ridge Lawn
 Russo, Mrs. Andrew E.....486 S. Main St.

East Chicago

Barron, Mrs. Elmer A.....3902 Ivy St.
 Campagna, Mrs. E. A.....4320 Ivy St.
 Ernst, Mrs. H. C.....4219 Baring Ave.
 Fleischer, Mrs. J. C.....4135 Ivy St.
 Grosso, Mrs. William G.....4132 Northcote Ave.
 Gustaitis, Mrs. John W.....4318 Parrish Ave.
 Niblick, Mrs. James S.....4115 Fir St.
 Shapiro, Mrs. Joseph.....4214 Parrish Ave.

East Gary

Mather, Mrs. J. Winford.....2367 Vigo St.
 Penn, Mrs. R. A.....2334 Vigo St.
 Valencia, Mrs. Monico.....2421 Walnut St.

Gary

Abramson, Mrs. Allen.....7001 E. 1st Ave.
 Almquist, Mrs. C. O.....550 Lincoln St.
 Angeles, Mrs. U. A.....729 Henry St.
 Armalavage, Mrs. L. J.....6572 Birch St.
 Barton, Mrs. Reginald.....71655 Birsh St.

Behn, Mrs. Walter.....1514 W. 5th St.
 Bergal, Mrs. M. B.....925 W. 35th Ave.
 Bills, Mrs. R. J.....444 Fillmore St.
 Bills, Mrs. R. N.....534 Lincoln St.
 Borenstein, Mrs. Hershel.....650 Buchanan St.
 Brady, Mrs. Samuel J.....451 Garfield St.
 Bringas, Mrs. Irinco B.....803 Johnson St.
 Brincko, Mrs. John.....3537 Harrison St.
 Burger, Mrs. Robert.....6735 Hemlock St.
 Cahue, Mrs. A. A.....350 Grant St.
 Carberry, Mrs. G. A.....591 Johnson St.
 Carbone, Mrs. Joseph A.....526 Johnson St.
 Cooper, Mrs. Leo K.....670 Hayes St.
 Dierolf, Mrs. Edward J.....630 Montgomery St.
 Elliott, Mrs. Ralph A.....1726 W. Sixth Ave.
 English, Mrs. Hubert M.....575 Taft St.
 Fadell, Mrs. Mathew J.....701 W. 55th Ave.
 Gallinatti, Mrs. J. J.....74413 Locust St.
 Glover, Mrs. W. J.....3540 Taylor Ave.
 Goldberg, Mrs. Harold B.....825 W. 35th Ave.
 Goldstone, Mrs. Adolph.....1430 W. Seventh St.
 Goldstone, Mrs. Joseph.....600 Cleveland St.
 Goldstone, Mrs. Sidney R.....1045 W. 35th Ave.
 Hadey, Mrs. James H.....800 Hayes St.
 Jahns, Mrs. A. A.....655 Roosevelt St.
 Jordon, Mrs. S. Y.....430 W. 44th Ave.
 Kendrick, Mrs. Frank J.....701 Polk St.
 Kobrin, Mrs. Meyer W.....2300 W. Sixth Ave.
 Kolletis, Mrs. J. G.....847 W. 45th St.
 Kopcha, Mrs. Joseph E.....650 Pierce St.
 Korn, Mrs. Jerome M.....2119 W. Fifth Ave.
 Lazo, Mrs. Vincent.....707 Harrison St.
 Lorenty, Mrs. T. B.....3654 Madison St.
 Manalo, Mrs. F. S.....538 Lincoln St.
 May, Mrs. R. Milton.....657 Van Buren St.
 Milos, Mrs. Robert.....725 Filmore St.
 Minczewski, Mrs. Richard C.....5528 Van Buren St.
 Morris, Mrs. Hyman R.....2401 W. Sixth Ave.
 Moswin, Mrs. Jack A.....701 Arthur St.
 Nelson, Mrs. W. A.....1050 Warren St.
 Nilges, Mrs. Richard.....237 Glen Park Ave.
 Ornelas, Mrs. Joseph F.....6339 Oakwood Lane
 Pappas, Mrs. Edward T.....569 Pierce St.
 Poracky, Mrs. Bernard F.....5598 Van Buren St.
 Radigan, Mrs. Leo R.....6624 Birch St.
 Robinson, Mrs. Walter K.....500 N. Montgomery St.
 Roth, Mrs. Leo.....7033 E. 1st Ave.
 Rubin, Mrs. Simon S.....2131 W. Fifth Ave.
 Ryan, Mrs. H. J.....630 McKinley St.
 Sala, Mrs. Joseph J.....2333 W. Fifth Ave.
 Sala, Mrs. Walter.....659 McKinley St.
 Schultz, Mrs. K. J.....4407 Ryan Ct.
 Scully, Mrs. J. T.....715 Johnson St.
 Senese, Mrs. Thomas J.....581 Johnson St.
 Shevick, Mrs. Alexander.....733 Filmore St.
 Slama, Mrs. George F.....3520 Polk St.
 Stimson, Mrs. Harry R.....4338 Jefferson St.
 Vye, Mrs. J. Preston.....3620 Madison St.
 Weiscopff, Mrs. H. S.....608 Roosevelt St.
 Yast, Mrs. Charles J.....740 Filmore St.
 Yocum, Mrs. Paul S. Jr.....2200 Ranburn
 Yocum, Mrs. Paul S., Sr.....6999 Hemlock St.
 Young, Mrs. G. M.....4580 Washington St.
 Zucker, Mrs. Edward.....7009 E. 1st St.

Griffith

Lundeborg, Mrs. Ralph A.....303 N. Harvey
 Siekierski, Mrs. J. M.....445 N. Broad Street

Hammond

Allegretti, Mrs. Michael L.....6237 Forest Ave.
 Bacevich, Mrs. A. J.....6939 Olcott Ave.
 Beconovich, Mrs. Robert.....6540 Forest Ave.
 Bombar, Mrs. Leslie E.....6826 Rosewood
 Bonaventura, Mrs. Angelo P.....7112 Woodmar Ave.
 Costello, Mrs. Albert J.....6737 Magoun Ave.
 Cotter, Mrs. Edward R.....7225 Knickerbocker
 Eggers, Mrs. Ernest.....635 165th St.
 Eggers, Mrs. H. W.....6542 Hobman Ave.

Egnatz, Mrs. Nick.....820 Highland St.
 Elledge, Mrs. Ray.....6415 Forest Ave.
 Fischer, Mrs. Burnell.....49 Indi-Illi Park
 Gardner, Mrs. A. J.....47 Waltham
 Gevirtz, Mrs. Milton B.....7142 Hohman Ave.
 Hack, Mrs. Edmund C.....7147 Olcott St.
 Hickman, Mrs. A. Lee, Jr.....7412 Knickerbocker
 Hopkins, Mrs. Gunner.....7107 State Line
 Howard, Mrs. Wm. H.....41 Glendale Pk.
 Husted, Mrs. Robert G.....7248 Forest Ave.
 Jones, Mrs. E. S.....50 Kenwood St.
 Kenney, Mrs. Francis D.....8131 Forest Ave.
 Komoroske, Mrs. John E.....35 Highland Ave.
 Koransky, Mrs. David S.....7048 Forest Ave.
 Kretsch, Mrs. Russell W.....7214 Hohman Ave.
 Lazo, Mrs. Vincente R.....707 Harrison St.
 Marks, Mrs. Ora L.....7111 Olcott Ave.
 Mason, Mrs. R. L.....132 Rimbach Ave.
 Modjeski, Mrs. Joseph R.....7327 Knickerbocker
 Modjeski, Mrs. Raymond J.....1448 Elliott Dr.
 Neal, Mrs. L. W.....7301 Forest Ave.
 Panares, Mrs. S. V.....4 172nd Place
 Peck, Mrs. Edward A.....6422 Moraine Ave.
 Pilot, Mrs. Jean.....7137 Knickerbocker Pkwy.
 Premuda, Mrs. Franklin F.....7042 Woodmor
 Remich, Mrs. Antone C.....6412 Moraine Ave.
 Rendel, Mrs. Donald T.....18 172nd St.
 Rhind, Mrs. A. W.....7126 Forest Ave.
 Ramker, Mrs. Donald.....7129 Arizina Ave.
 Rosevere, Mrs. Herry J.....6531 Forest Ave.
 Row, Mrs. Perry Quentin.....6706 Hohman Ave.
 Rubright, Mrs. Robert.....7025 Monroe Ave.
 Rudolph, Mrs. F. G.....6607 Forest Ave.
 Santare, Mrs. Vincent J.....6508 Forest Ave.
 Schlissenger, Mrs. Jacob.....7648 Hohman Ave.
 Shulruff, Mrs. Harry I.....7244 Hohman Ave.
 Shanklin, Mrs. E. M.....54 Ruth St.
 Stern, Mrs. S. Lewis.....226 Oakwood
 Teegarden, Mrs. Joseph A., Jr.....7204 Woodman Ave.
 Thegze, Mrs. George A.....7435 Olcott Ave.
 Trachtenberg, Mrs. Lee.....7411 White Oak
 Wong, Mrs. Samuel N.....632 169th St.

Bernard, Mrs. Marvin R.....651 Waters, Hobart
 Kellar, Mrs. Philip F.....1331 Lincoln St., Hobart
 Dhein, Mrs. Donald T.....6744 Jefferson St., Merrillville

Espino, Mrs. J. C.....8523 Wentworth, Calumet City, Ill.
 Dimitroff, Mrs. Lambro.....849 Wentworth Ave., Calumet City, Ill.
 Mansueto, Mrs. Mario D.....4 Forestdale, Calumet City, Ill.
 Sroka, Mrs. A. G.....17216 Wentworth Ave.,
 Lansing, Ill.
 Stasick, Mrs. Murray.....228 W. Warren, Lansing, Ill.
 Brenner, Mrs. Howard.....15510 Dante, Dolton, Ill.
 Portney, Mrs. Fred.....15520 Dante, Dolton, Ill.
 Markey, Mrs. R. J.....Rosedale Terrace, Lincolnshire, Crete, Ill.
 Palmer, Mrs. Russell H.....Postville, Iowa

Highland

Beilke, Mrs. G. A.....8723 Parkway Dr.
 Larrabee, Mrs. James.....2214 Oakedale
 Smitley, Mrs. R. B.....3330 LaPorte
 Tika, Mrs. E. C.....8740 Parkway Dr.
 White, Mrs. G. H., Jr.....8754 Parkway Dr.

Munster

Arbeiter, Mrs. Herbert L.....119 Beverly Place
 Arrowsmith, Mrs. James L.....8131 Forest Ave.
 Benchik, Mrs. Frank A.....8326 Hawthorne Dr.
 Boys, Mrs. F. F.....8517 Crestwood Ave.
 Chael, Mrs. Tom C.....225 Belmont Place

Dow, Mrs. J.....8356 Hawthorn
 Kenney, Mrs. Francis.....8131 Forest Ave.
 Kuhn, Mrs. Arthur J.....1535 35th St.
 Lanman, Mrs. John U.....1448 MacArthur Blvd.
 Lautz, Mrs. Herbert A.....7943 Forest Ave.
 Long, Mrs. Keith J.....1327 Ridgeway
 Madlang, Mrs. R. M.....7750 Hohman
 Marks, Mrs. Salvo P.....8320 Parkview Ave.
 Mintz, Mrs. Alfred M.....1423 Kraft Dr.
 McLean, Mrs. James S.....7836 Ridge Rd.
 Paul, Mrs. Eudell G.....7905 Hohman
 Rasch, Mrs. George C.....1519 35th St.
 Rosenthal, Mrs. Carl.....8330 Schrieber Dr.
 Schlesinger, Mrs. D. J.....1506 MacArthur Blvd.
 Schleisinger, Mrs. Jack.....7648 Hohman Ave.
 Shapiro, Mrs. S. W.....1517 Melbrook
 Smith, Mrs. Jerald.....303 Fairbanks
 Sroka, Mrs. Stanley J.....7540 Forest Ave.
 Stevens, Mrs. Edwin W.....8627 Beech
 Teplinsky, Mrs. L. L.....1528 Twelve Oaks Dr.
 Westhaysen, Mrs. Peter V.....127 Beverly Pl.

Whiting

Angel, Mrs. Virgil.....2125 Indianapolis Blvd.
 Greisen, Mrs. J. C.....1709 Stanton Ave.
 Weinberg, Mrs. B. A.....2022 Lake Ave.

LA PORTE COUNTY

Michigan City

Armstrong, Mrs. Thomas D.....215 E. Coolsprings
 Bankoff, Mrs. M. L.....307 Kenwood
 Berkson, Mrs. Myron.....3137 Cleveland Ave.
 Cleveland, Mrs. John B.....Mounted Route 5, Box 68
 Fargher, Mrs. Francis M.....Pottawattamie Pk.
 Frost, Mrs. Robert.....405 Wilshire Ave.
 Gardner, Mrs. M. D.....1520 E. 8th St.
 Gardner, Mrs. Russell A.....Stop 29, Long Beach
 Given, Mrs. E. H., Jr.....2805 Lake Shore Dr., Long Beach

Jones, Mrs. King S.....1010 E. Coolsprings
 Kemp, Mrs. John T.....122 E. Seventh St.
 Kubik, Mrs. Francis R.....Pottawattamie Pk.
 Liddell, Mrs. Charles K.....3007 Mayfield Way, Long Beach

Marske, Mrs. Robert.....1120 Buffalo St.
 Taub, Mrs. Robert G.....113 Valentine Ct.
 Tunnell, Mrs. Harry D.....107 W. 4th St.
 Walters, Mrs. William.....2724 Lake Shore Dr., Long Beach

LaPorte

Backer, Mrs. G. P.....1533 Michigan Ave.
 Carpentier, Mrs. Ben.....LaPorte
 Carter, Mrs. Fred.....208 Forest Dr.
 Datzman, Mrs. Basil.....906 Fox St.
 Durham, Mrs. Lowell.....1808 Indiana Ave.
 Erwin, Mrs. Robert.....505 Third St.
 Kelsey, Mrs. Robert M., Jr.....1305 Indiana
 Kelsey, Mrs. Robert.....2107 Monroe St.
 Kepler, Mrs. R. W.....1529 Michigan Ave.
 Larson, Mrs. G. O.....Ridgefield Add'n
 Mead, Mrs. Frank.....344 Grayson Rd.
 Mueller, Mrs. Edwin.....1229 Weller Ave.
 Muhleman, Mrs. Charles E.....Greenacres
 Philbrook, Mrs. S. S.....212 Forest Dr.
 Richter, Mrs. John.....1421 Indiana Ave.
 Von Asch, Mrs. George.....2030 Michigan Ave.
 Wolfe, Mrs. Wm. E.....Lakewood Lair, The Island

Westville

Deiter, Mrs. Wm.....P. O. Box 473
 Johnston, Mrs. Donald.....P. O. Box 473
 Oster, Mrs. Jack H.....102 Beatty Circle, P. O. Box 473
 Wygant, Mrs. Marion D.....P. O. Box 473

LAWRENCE COUNTY**Bedford**

Allen, Mrs. L. Howard.....1318 14th St.
 Austin, Mrs. Richard P.....1315 15th St.
 Campbell, Mrs. William T.....348 Eastwood Dr.
 Duncan, Mrs. Raymond E.....116 Edgewood Dr.
 Dusard, Mrs. Joseph C.....1107 N St.
 Edmonds, Mrs. Kendrick T.....1303 15th St.
 Emery, Mrs. Charles B.....Brook Knoll
 Fahrigner, Mrs. Robert R.....1506 13th St.
 Fey, Mrs. Charles W.....417 Northwood Dr.
 Fountaine, Mrs. Thomas J.....1620 18th St.
 Hammel, Mrs. Howard T.....1822 15th St.
 Hawkins, Mrs. Richard D.....1308 15th St.
 Kastings, Mrs. Gerald E.....Parkview Addition
 Kerr, Mrs. Donald M.....1415 20th St.
 Morrow, Mrs. Robert J.....501 Southwood St.
 Noe, Mrs. William R.....118 Woodhill Dr.
 Scherschel, Mrs. John P.....1713 H St.
 Waldo, Mrs. Guy Harold Jr.....308 Eastwood Dr.
 Wohlfeld, Mrs. J. B.....1224 15th St.
 Woolery, Mrs. Richard R.....2020 Denson Ave.
 Wynne, Mrs. R. E.....1601 16th St.

Hamilton, Mrs. James.....703 Oak St., Mitchell
 Oswalt, Mrs. James.....901 Curry St., Mitchell
 Robinson, Mrs. William.....R. R. 1, Mitchell
 Benham, Mrs. Lawrence E.....R. R. 2, Springville

MADISON COUNTY

LeRoy, Mrs. A. G.....Alexandria

Anderson

Aagesen, Mrs. W. J.....3 Wind Ridge
 Armington, Mrs. Charles L.....823 W. 7th Street
 Armington, Mrs. John C.....206 W. 14th St.
 Austin, Mrs. Charles E.....1612 Westwood Dr.
 Baughn, Mrs. W. L.....1517 Winding Way
 Beeler, Mrs. Frank K.....20 Overlook Dr.
 Bixler, Mrs. Donald P.....1515 Green Way Dr.
 Blassaras, Mrs. Crist A.....916 Dresser Dr.
 Bowers, Mrs. Richard C.....3508 Dogwood Dr.
 Bridges, Mrs. Alvin L.....R. R. 2, Box 296 a
 Brown, Mrs. James M.....909 Forest Dr.
 Buckles, Mrs. David L.....44 Knoll Rd.
 Conrad, Mrs. Ernest M.....2124 Meridian St.
 Doenges, Mrs. James L.....1601 Van Buskirk Rd.
 Donaldson, Mrs. Frank C.....308 Winding Way
 Drake, Mrs. James R.....1104 Pearl St.
 Drake, Mrs. John C.....920 N. Madison Ave.
 Dulin, Mrs. Basil B.....1120 Maryland Drive
 Ellis, Mrs. Seth W.....1105 Green Way Dr.
 Elsten, Mrs. Wayne A.....1333 Maryland Dr., Forest Manor

Erehart, Mrs. Archie D.....1221 Irving Way
 Faust, Mrs. Howard Jr.....1321 W. 8th St.
 Ferguson, Mrs. Donald H.....3430 Redwood Rd.
 Fischer, Mrs. Warren E.....1410 Van Buskirk Rd.
 Gante, Mrs. Henry W.....2005 Nichol Ave.
 Hart, Mrs. Wm. D.....1026 W. Eighth St.
 Jarrett, Mrs. Paul E.....2541 N. Shore Blvd.
 Jones, Mrs. Albert T.....3316 Cherry Rd.
 Jones, Mrs. David G.....126 W. 12th St.
 Kelly, Mrs. Wendell C.....23 Colony Rd.
 Kiely, Mrs. John T.....1011 Raible Ave.
 King, Mrs. Joseph W.....260 Davis Dr.
 Kopp, Mrs. William R.....1200 Arrow Ave.
 Lamey, Mrs. Paul T.....1740 W. 10th St.
 Land, Mrs. Richard.....509 Pershing Dr.
 Larmore, Mrs. Joseph L.....1301 Winding Way
 Litztenberger, Mrs. Sam W.....837 Forrest Dr.
 Long, Mrs. Paul L.....828 Dresser Dr.
 Metcalf, Mrs. George B.....830 W. Eighth St.
 Moneyhun, Mrs. James E.....1815 Ivy Dr.
 Morris, Mrs. Robert A.....410 Golf Club Rd.
 Neale, Mrs. Alfred E.....725 Forest Dr.
 Nesbitt, Mrs. Leonard L.....60 River Forest
 Patterson, Mrs. William K.....8 South Park Dr.

Polhemus, Mrs. Warren C.....1800 W. 11th St.
 Rosenbaum, Mrs. Lloyd E.....804 Dresser Dr.
 Ross, Mrs. Guy E.....1124 N. Madison Ave.
 Sharp, Mrs. William L.....725 North Shore Blvd.
 Sheldon, Mrs. Suel A.....2812 Greenbriar Rd.
 Stamper, Mrs. Joseph H.....619 State Road 67 W.
 Stamper, Mrs. Robert J.....3104 Sherman St.
 Starks, Mrs. William O.....2536 W. 12th St.
 Stinson, Mrs. William M.....17 River Forest
 Swan, Mrs. Richard C.....707 Forrest Dr.
 Wagoner, Mrs. John R.....3522 Hawthorne Rd.
 Weiss, Mrs. Louis L.....1225 N. Madison Ave.
 Webb, Mrs. Harry D.....1308 Maryland Dr.
 Wilder, Mrs. Gordon B.....338 W. Eighth St.
 Williams, Mrs. Francis M.....1012 Park Rd.
 Williams, Mrs. Robert H.....715 North Shore Blvd.
 Wilkinson, Mrs. Roger L.....1525 Winding Way
 Wishard, Mrs. Fred B.....2604 E. 4th St.

Ayres, Mrs. Kenneth D.....R. R. 1, Markleville
 Williams, Mrs. Robert D.....Markleville
 Hammer, Mrs. J. W.....Middletown
 McLaughlin, Mrs. Calvin P.

Fall Creek Parkway, Pendleton
 Van Ness, Mrs. William.....216 S. Main, Summitville
 Bishop, Mrs. Harry A.....Frankton

MARION COUNTY

Dill, Mrs. Charles W.

4111 S. Sherman Drive, Beech Grove
 Ramage, Mrs. Walter F.....244 S. First, Beech Grove

Indianapolis**A**

Albertson, Mrs. Frank P.....5031 Rockville Rd. (28)
 Aldrich, Mrs. Harry D.....5805 Sherman Dr. (20)
 Allen, Mrs. Robert K.....737 Sherwood Dr. (20)
 Alvis, Mrs. Edmond O.....474 W. 92nd St. (8)
 Anshutz, Mrs. W. M.....5429 N. Sadlier Dr. (26)
 Antreasian, Mrs. Berj.....615 N. Peyton Rd.
 Appel, Mrs. Richard H.....4465 Marcy Lane, No. 190 (5)
 Arbuckle, Mrs. William E.....5326 E. St. Joseph St. (19)
 Armer, Mrs. Robert M.....4031 N. Ritter (26)
 Arnold, Mrs. Robert D.....6450 Around the Hills Road (26)
 Aust, Mrs. Charles H.....1119 N. Linwood Ave. (1)
 Avery, Mrs. George O.....5321 N. Kessler Blvd. N.D. (8)

B

Bachmann, Mrs. Arnold J.....1615 Oles Drive (8)
 Bakemeier, Mrs. Otto H.....5535 E. St. Clair St. (19)
 Bakemeier, Mrs. Robert E.....1210 N. Butler Ave. (19)
 Balch, Mrs. James E.....4444 College Ave. (5)
 Ball, Mrs. Joseph E.....6612 E. Ninth St. (19)
 Banks, Mrs. Horace M.....3631 Forest Manor Ave. (18)
 Baptisti, Mrs. Arthur, Jr.....4401 N. Meridian St. (8)
 Barrett, Mrs. Robert V.....408 Arthur Ave. (24)
 Bartley, Mrs. Max D.....5640 N. Pennsylvania St. (20)
 Batman, Mrs. Gordon W.....6906 N. Delaware St. (20)
 Battersby, Mrs. Stanley.....6262 Washington Ave. (20)
 Baumeister, Mrs. Herbert E.....4421 E. 75th (20)
 Beach, Mrs. Robert R.....5810 E. Pleasant Run Pkwy., N. Dr. (19)
 Beamer, Mrs. Parker R.....4620 Boulevard Place (8)
 Beasley, Mrs. Thos. J.....715 E. 70th Place (20)
 Beaver, Mrs. Howard W.....303 E. Edgewood Ave. (27)
 Beck, Mrs. Evart M.....6445 N. Olney St. (20)
 Becker, Mrs. Harry G.....5641 Haverford Ave. (20)
 Beeler, Mrs. John W.....7974 N. Illinois St. (20)
 Belt, Mrs. James H.....8271 Forest Lane (20)

Benedict, Mrs. Paul F. . . . 2550 Blue Grass Dr. (8)
 Bennett, Mrs. Ivan F. . . . R. R. 18, Box 285 (24)
 Berman, Mrs. J. K. . . . 2810 W. 38th St. (8)
 Bibler, Mrs. Lester D. 4360 N. Pennsylvania St. (5)
 Bill, Mrs. Robert O.

8750 Washington Blvd., W. Dr. (20)
 Blake, Mrs. Albert L. . . . 6471 Knyghton Rd. (20)
 Blatt, Mrs. A. Ebner. . . . 5330 N. Illinois St. (8)
 Boling, Mrs. Grover C., Jr.

6205 Bramshaw Rd. (20)
 Booth, Mrs. Boynton H. . . . 5735 Braewick Rd. (26)
 Bowman, Mrs. George W.

5634 Carrollton Ave. (20)
 Boyer, Mrs. Floyd A. . . . 136 S. Wittfield St. (19)
 Brady, Mrs. Thomas A., Jr.

225 Wellington Rd. (20)
 Brayton, Mrs. John R.

3128 E. Fall Creek Blvd., N. Dr. (5)
 Brayton, Mrs. Lee. . . . 5540 N. Illinois St. (8)
 Brickley, Mrs. Richard A.

5954 Hillside, W. Dr. (20)
 Brillhart, Mrs. James R. . . . 5731 Kilmer Lane (20)
 Brodie, Mrs. Donald W. . . . R. R. 13, Box 397 (26)
 Brown, Mrs. Archie E.

4145 Melbourne Rd., W. Dr. (8)
 Brown, Mrs. DeWitt W., Jr.

4363 Cold Springs Rd. (8)
 Brown, Mrs. Gordon T. . . . 3325 Breckenridge Dr. (8)
 Brown, Mrs. Thomas C., Jr.

8780 Driftwood Dr. (20)
 Brown, Mrs. Wendell E. . . . 3750 N. Gale St. (18)
 Browning, Mrs. James S.

6339 N. Keystone Ave. (20)
 Burdette, Mrs. Harold. . . . 5733 Broadway (20)
 Burghard, Mrs. Rolla D. . . . 4340 Berkshire Rd. (18)
 Butler, Mrs. Robert M. . . . 4849 N. Ritter Ave. (26)

C

Call, Mrs. Herbert F. . . . 710 E. 57th St. (20)
 Calvert, Mrs. John H., Jr. . . . 4450 Guilford Ave. (5)
 Campbell, Mrs. E. . . . 5739 Haverford (20)

Campbell, Mrs. John A. . . . 5201 Grandview Dr. (8)
 Campbell, Mrs. Robert L. . . . 5726 Sherman Ave. (20)
 Carson, Mrs. E. Wayne. . . . 7177 N. Meridian St. (20)

Carter, Mrs. Oren E. . . . 5461 Kenwood Ave. (8)
 Chatten, Mrs. William R. . . . 4209 Roselawn Dr. (18)
 Chernish, Mrs. Stanley M. . . . 4403 Radnor Rd. (26)

Chevalier, Mrs. R. B. . . . 6834 Mohawk Lane (20)
 Chivington, Mrs. Paul B., Jr. . . . 5730 N. Parker (20)
 Chroniak, Mrs. Walter

5916 E. Pleasant Run Pkwy., N. Dr. (19)
 Clark, Mrs. Geo. A. . . . 1041 Bristol Rd. (20)
 Clark, Mrs. Lawson J.

2725 E. Kessler Blvd., E. Dr. (20)
 Coddington, Mrs. Robert C.

2261 N. Centennial (22)
 Coggeshall, Mrs. Warren E.

6305 Bramshaw Rd. (26)
 Cohn, Mrs. Alvin F. . . . 1120 Southview Dr. (27)
 Collins, Mrs. J. N. . . . 5445 N. Pennsylvania (20)

Conway, Mrs. Glenn. . . . 2235 E. Garfield Dr. (3)
 Cortese, Mrs. James V. . . . 6302 Minlo Dr. (27)
 Cortese, Mrs. Thomas A. . . . 3240 Brill Rd. (27)

Cox, Mrs. C. E. . . . 1950 W. 71st St. (8)
 Crawford, Mrs. John A. . . . 3848 Washington Blvd. (5)
 Cross, Mrs. David G. . . . 3001 Redfern Dr. (27)

Culbertson, Mrs. C. G. . . . 6060 Park Ave. (20)
 Cullen, Mrs. P. K. . . . 5115 Graceland Ave. (8)
 Currie, Mrs. Robert W. . . . 512 E. 57th St. (20)

Curry, Mrs. R. Louis. . . . 5260 Carrollton (20)
 Daley, Mrs. Edward H.

5118 East Dickson Road (26)
 Dallas, Mrs. F. R. . . . 7935 E. Michigan (19)
 Daly, Mrs. Joseph M. . . . 5969 Singleton Ave. (27)

Davis, Mrs. Sam J. . . . 4545 Broadway (5)
 Dearmin, Mrs. Robert M. . . . 5147 N. Delaware St. (5)

D

DeArmond, Mrs. Albert M.

5401 N. Delaware St. (20)
 Deever, Mrs. John W. . . . 6801 S. East St. (27)
 Denny, Mrs. James W.

6633 Spring Brook, N. Dr. (19)
 Donato, Mrs. Albert M. . . . 5915 Lawrence Dr. (26)
 Doran, Mrs. J. Hal. . . . 3733 N. Denny St. (18)

Dorman, Mrs. W. Leland
 6631 Spring Brook, N. Dr. (19)
 Doughty, Mrs. Samuel R., Jr.

5817 N. Dearborn St. (20)
 Dowd, Mrs. Joseph A. . . . 7055 Central Ave. (20)
 Drew, Mrs. Arthur L., Jr. . . . 333 Beverly Dr. (5)

Dryden, Mrs. Gale. . . . 5835 N. Tacoma Ave. (20)
 Dugan, Mrs. William M.

5747 Rolling Ridge Rd. (20)
 Dupes, Mrs. Lowell E. . . . 5851 White Oak Ct. (20)
 Dyar, Mrs. Edwin W., Jr.

5910 Washington Blvd. (20)
 Dyke, Mrs. Richard W. . . . 6314 Hoover Road (8)

E

Eastman, Mrs. Joseph Rilus. . . . 220 W. 64th St. (8)
 Eaton, Mrs. Edwin R. . . . 5750 Allisonville Rd. (20)
 Eaton, Mrs. Lyman D. . . . R. R. 19, Box 487Y (20)

Ebert, Mrs. J. Wayne. . . . 1125 Southview Dr. (27)
 Egbert, Mrs. Herbert L. . . . 419 W. 63rd St. (8)
 Eicher, Mrs. Palmer O. . . . 4401 Washington Blvd. (5)

Eldridge, Mrs. Gail E. . . . 5746 Central Ave. (20)
 Elkins, Mrs. James P. . . . 2045 Lick Creek Dr. (3)
 Ellis, Mrs. Bert E. . . . 2595 N. Girls School Rd. (24)

Ellis, Mrs. William N. . . . 4908 E. 46th Street (26)
 Emhardt, Mrs. John T. . . . 3305 Brill Rd. (27)
 Emhardt, Mrs. John W.

5425 Washington Blvd. (20)
 Englebert, Mrs. Esther C.
 327 N. Layman Ave. (19)

Ensminger, Mrs. Leonard A.
 1321 N. Meridian St. (2)
 Evans, Mrs. Paul V. . . . 7415 Dean Rd. (20)

Everly, Mrs. Ralph V. . . . 1105 E. 58th St. (20)

F

Fausset, Mrs. C. Basil. . . . 7757 N. Meridian St. (20)
 Ferry, Mrs. Francis A. . . . 935 Southern Ave. (3)
 Finneran, Mrs. Joseph C. . . . 3819 N. Delaware St. (5)

Fischer, Mrs. A. Alan. . . . 3230 W. 41st St. (8)
 Fisher, Mrs. F. C. . . . 3306 Meadows Ct., Apt. E3
 Flanagan, Mrs. Paul M. . . . 415 E. 48th St. (5)

Flanders, Mrs. Robert, Jr. . . . 5930 N. Olney St. (20)
 Flanigan, Mrs. Meredith B. . . . 3305 Rutledge Dr. (8)
 Flora, Mrs. Joseph O. . . . 5604 Rockville Rd. (24)

Folkner, Mrs. Norval C. . . . 5501 Camden (27)
 Fouts, Mrs. Paul J. . . . 8393 N. Illinois St. (20)
 Franklin, Mrs. William L. . . . 33 E. 37th St.

Freeman, Mrs. Leslie W. . . . 5461 Julian Ave. (19)
 Freeman, Mrs. Max E. . . . 4802 Thornleigh Dr. (26)
 French, Mrs. Richard N., Jr.

440 N. Winona St., Apt. 324 (2)
 Fry, Mrs. Robert D. . . . 5717 Broadway (20)

G

Gabovitch, Mrs. E. R. . . . 2707 E. 58th St. (20)
 Gaddy, Mrs. Nelson D. . . . 2551 Blue Grass Ct. (8)
 Gambill, Mrs. W. D. . . . 2272 Wynnedale Rd. (8)

Garber, Mrs. J. Neill. 7036 N. Pennsylvania St. (20)
 Garceau, Mrs. George J.

5539 N. Pennsylvania St. (20)
 Gardiner, Mrs. Sprague H. . . . 330 W. 62nd St. (8)
 Gardner, Mrs. Buchman. . . . 22 E. 52nd St. (5)

Garner, Mrs. W. Stanley. 4021 Cranbrook Dr. (20)
 Garrett, Mrs. Robert A. . . . 95 Wellington Rd. (8)
 Gastineau, Mrs. Frank M.

5344 N. Pennsylvania St. (20)
 Geider, Mrs. Roy A.
 5816 Pleasant Run Pkwy., N. Dr. (19)

Gick, Mrs. Herman H. . . . 451 Eastern Ave. (1)
 Gifford, Mrs. Fred E. . . . 5125 N. Meridian St. (8)

Gillespie, Mrs. Charles F. 4530 Berkshire Rd. (18)
 Gillespie, Mrs. Jacob E. 4426 Broadway (5)
 Ginsbery, Mrs. S. T. 7222 Stevens Lane (20)
 Goldman, Mrs. Samuel 428 Woodmere Dr. (20)
 Gormley, Mrs. Joseph J. 4402 Thrush Drive (24)
 Gosman, Mrs. James H. 4491 Washington Blvd. (5)
 Graham, Mrs. John D. 6401 Osborn Dr. (26)
 Greene, Mrs. Morgan E. 3029 E. Hanna Ave. (27)
 Greist, Mrs. John H. 4343 Washington Blvd. (5)
 Griffith, Mrs. Richard S. 2002 Cunningham Road (24)

Grisell, Mrs. Ted L. 5411 Broadway (20)
 Gruber, Mrs. Charles M., Jr. 3102 Kessler Blvd., E. Dr. (20)
 Gustafson, Mrs. Gerald W. 5768 N. Pennsylvania St. (20)

H

Habegger, Mrs. E. Dale 3120 W. 51st St. (8)
 Hadley, Mrs. David 5601 N. Pennsylvania St. (20)
 Haggard, Mrs. Edmund B. 5914 N. Emerson Ave. (20)
 Hall, Mrs. Frank M. 8633 N. Pennsylvania St. (20)
 Hall, Mrs. Jack H. 6241 E. 43rd St. (26)
 Hampshire, Mrs. Donald R. 7979 Morningside Dr. (20)

Hann, Mrs. Eldon C. 4217 N. Leslie (26)
 Hanna, Mrs. Thomas A. 5009 W. 15th St.
 Harcourt, Mrs. Allan K. 5418 Allisonville Rd. (8)
 Harding, Mrs. M. Richard 4220 DeVon Court (18)
 Harger, Mrs. Robert W. 46 West 52nd Street (8)
 Harold, Mrs. Norris E. 3545 N. Denny St. (18)
 Harvey, Mrs. Verne K., Sr. 1481 W. Tenth
 Haslinger, Mrs. Clarence J. 5236 Boulevard Pl. (8)
 Hatfield, Mrs. Nicholas W. 4118 N. Pennsylvania St. (5)

Haymond, Mrs. Joseph L. 2745 Crescent Hill Lane (8)
 Haynes, Mrs. John Thomas 4616 Cherry Lane (8)
 Hays, Mrs. Everett L. 2607 Manker Ave. (3)
 Healey, Mrs. Robert J. 5559 Washington Blvd. (20)
 Hedrick, Mrs. Philip W. 4808 Central Ave. (5)
 Heimbarger, Mrs. R. F. 4462 Central Ave. (5)
 Helman, Mrs. Charles H. 3253 Welch Cr. (24)
 Helmer, Mrs. O. M. 5015 N. Illinois St. (8)
 Henderson, Mrs. Wm. 846 W. Dr., Woodruff Pl.
 Hendricks, Mrs. John W. 124 W. 64th St. (20)
 Hepburn, Mrs. Charles K. 7570 Morningside Dr. (20)

Hetherington, Mrs. John A. 445 E. 71st St.
 Heubi, Mrs. John E. 6904 N. Park Ave. (20)
 Hickam, Mrs. John B. 7050 N. Pennsylvania St. (20)

Hickman, Mrs. Jack W. 4134 Sun Meadow Lane (8)
 Hickman, Mrs. Walter F. 5859 Gladden Dr. (20)
 Hildrup, Mrs. Don G. 5672 N. Illinois St. (8)
 Holman, Mrs. Jerome E., Jr. 5930 Central Ave.
 Hood, Mrs. Ainslee A. 1810 Rosedale Drive (27)
 Howell, Mrs. Joseph D. 4514 E. 79th St. (20)
 Howell, Mrs. Robert D. 6941 Washington Blvd. (20)

Huddle, Mrs. John E. 4738 N. Pennsylvania St. (5)
 Hudson, Mrs. Foster J. 525 W. Hampton Dr. (8)
 Hull, Mrs. Ronald H. 6465 Dover Rd. (20)
 Hurteau, Mrs. William W. 201 West 75th St. (20)
 Huse, Mrs. Wm. Murray 5131 N. Pennsylvania St. (5)

I-J

Irwin, Mrs. Glenn W., Jr. 8025 N. Illinois St. (20)
 Iske, Mrs. Paul G. 5207 Central (20)
 Jaeger, Mrs. Alfred S. 3057 Washington Blvd. (5)
 Jaquith, Mrs. Orville S. 261 Blue Ridge Rd. (8)
 Jay, Mrs. Arthur N. 815 West 64th St. (8)
 Jennings, Mrs. Frank L. 2601 Cold Springs Rd. (22)
 Jewett, Mrs. Joe H. 5803 Sherman Ave. (20)
 Jinks, Mrs. Clifford H. 1831 E. 61st St. (20)

Johnson, Mrs. Thomas W. 5735 Washington Blvd. (20)
 Jones, Mrs. Allen W. 6420 Around the Hills Rd. (26)
 Jones, Mrs. David E. 5433 Hawthorne Dr. (26)
 Joseph, Mrs. Rex M. 620 Hickory Lane (27)
 Jowitt, Mrs. Richard H. 5390 Brendonridge Rd. (26)
 Judson, Mrs. Walter E. 844 Fleetwood Dr. (8)

K

Kammen, Mrs. Leo 7030 Central Ave. (20)
 Katterjohn, Mrs. James C. 9035 Pickwick Dr. (20)
 Keenan, Mrs. George 2015 E. Thompson Rd. (27)
 Keenan, Mrs. Reid L. 3702 N. Delaware St. (5)
 Keever, Mrs. Charles H., Sr. 9016 Keever Dr., R. R. 18, Box 289B (24)
 Keiser, Mrs. Venice D. 5709 Broadway (20)
 Kelly, Mrs. Walter F. 6845 E. Pleasant Run Pkwy., S. Dr. (19)
 Kennedy, Mrs. Hunter F. 757 N. Bolton Ave. (19)
 Kennedy, Mrs. Joseph T. 4046 Sheridan Ave. (26)
 Kenney, Mrs. David B. 6711 E. Tenth St. (19)
 Kenzler, Mrs. Jack I. 4140 Flamingo, E. Dr. (26)
 Kerr, Mrs. Harry R. 5774 Washington Blvd. (20)
 King, Mrs. Harold K. 4606 Washington Blvd. (5)
 Kingsbury, Mrs. John K. 5776 E. Michigan St. (19)
 Kirtley, Mrs. William R. 7447 N. Park Ave. (20)
 Kiser, Mrs. Edgar F. 5610 Central Ave. (20)
 Kissel, Mrs. Wesley A. 2368 N. Auburn (24)
 Kitterman, Mrs. Harry E. 5108 Graceland (8)
 Klain, Mrs. Benjamin V. 8419 N. Pennsylvania St. (20)

Knowles, Mrs. Charles Y. 4340 Glencairn Ln. (18)
 Knowles, Mrs. Robert P. R. R. 18, Box 271 (24)
 Kohlstaedt, Mrs. Kenneth G. 645 E. 80th St. (20)
 Kooiker, Mrs. J. E. 3540 Watson Road (5)
 Koons, Mrs. Karl M. 5767 N. Pennsylvania St. (20)
 Kornafel, Mrs. Laddie H. 6201 College Ave. (20)
 Kuntz, Mrs. Herman W. 2065 Lick Creek Drive (3)

Kurlander, Mrs. Gerald J. 3720 N. Meridian St. (8)
 Kwitney, Mrs. I. J. 5774 Broadway Terrace (20)

L

LaDine, Mrs. Clarence B. 4221 E. 35th St. (18)
 Lamb, Mrs. Emmett B. 1180 Golden Hill Dr. (8)
 Lamb, Mrs. Russell W. 4636 N. Capitol Ave. (8)
 Lang, Mrs. Erich K. 107 E. 48th St. (5)
 Laramore, Mrs. Ward 2527 McLeay Dr. (20)
 Lawler, Mrs. George F. 5601 E. St. Clair St. (19)
 Leasure, Mrs. J. Kent 3115 N. Meridian (8)
 Leff, Mrs. Abe H. 160 Pennridge Dr.
 Leffler, William T. 250 E. 70th St. (20)
 LeMaster, Mrs. Theodore R. 2621 McLeay Dr. (20)

Levi, Mrs. Leon 6902 N. Pennsylvania St. (20)
 Lewis, Mrs. Earl 380 S. Kenmore (19)
 Lewis, Mrs. Robert J. 5800 Lawrence Dr. (26)
 Lichtenberg, Mrs. Melvin 5677 N. Meridian St. (8)

Lindenberg, Mrs. Paul G. 4304 E. 46th St. (26)
 Lingeman, Mrs. Raleigh E. 3845 N. Meridian St. (8)

Lochry, Mrs. Ralph L. 63 Isle of Venice #11, Ft. Lauderdale, Fla.
 Loehr, Mrs. Wm. M. 1426 E. Kessler Blvd. (20)
 Lord, Mrs. Glenn C. 4455 Washington Blvd. (5)
 Loudon, Mrs. Robert W. 1510 Marion Dr. (20)
 Loughlin, Mrs. Leo 5410 N. Pennsylvania St. (20)
 Love, Mrs. George N. 5331 Washington Blvd. (20)
 Lozow, Mrs. David 5545 N. Meridian (26)
 Lukemeyer, Mrs. George T. 3845 N. Campbell Ave. (26)

Lunsford, Mrs. Thomas E. 4714 W. 30th (24)
 Lurie, Mrs. Paul R. 5 W. 79th St. (20)
 Luros, Mrs. J. Theodore 156 Fairway Dr. (20)
 Lybrook, Mrs. William B. 4585 Kessler Blvd., E. Dr. (20)

M

McCartney, Mrs. Donald H. . . . 410 East 56th St. (20)
 McClain, Mrs. Edwin S. . . . 550 W. 77th St., N. Dr. (20)
 McCormick, Mrs. Charles O., Jr. . . . 4240 Glencairn Lane (18)
 McGrath, Mrs. Michael F. . . . 6183 Washington Blvd. (20)
 McGuff, Mrs. Paul E. . . . 3660 Central Ave. (5)
 McLaren, Mrs. Daniel E. . . . 4479 Barnor Dr. (26)
 McQuiston, Mrs. Ralph J. . . . 6120 Lawrence Dr. (26)
 McTurnan, Mrs. Robert W. . . . 6967 Central Ave. (20)
 Mackey, Mrs. John E. . . . 940 W. 58th St. (8)
 Madden, Mrs. Robert J. . . . 1543 N. Euclid Ave. (1)
 Malcolm, Mrs. R. L., Jr. . . . 401 N. Arthur Ave. (24)
 Manders, Mrs. Karl L. . . . 215 E. 71st Street (20)
 Manion, Mrs. Marlow W. . . . 5132 N. New Jersey St. (5)

Mann, Mrs. Richard E. . . . 4350 Lincoln (8)
 Manning, Mrs. Randolph . . . 5302 N. Delaware St. (20)
 Manzie, Mrs. Michael. . . . 2687 W. 44th St. (5)
 Marks, Mrs. Maurice I. . . . 152 Fairway Dr. (20)
 Marsh, Mrs. Carl M. . . . 4112 Marrison Place (18)
 Marshall, Mrs. Albert L., Jr. . . . 7802 Allisonville Rd. (20)

Marshall, Mrs. Cavins R. . . . 4162 N. Meridian St. (8)
 Martin, Mrs. Loren H. . . . 5338 Washington Blvd. (20)
 Martz, Mrs. Carl D. . . . 7926 Hawthorn Ct. (26)
 Masters, Mrs. John M. . . . 34 E. 46th St. (5)
 Matthew, Mrs. W. Burleigh . . . 800 W. Kessler Blvd. (5)

Matthews, Mrs. B. J. . . . 966 N. Graham (19)
 Matthews, Mrs. William M. . . . 1122 N. Bolton Ave. (19)

Maxam, Mrs. Beverly T. . . . 6220 Sunset Lane (24)
 Megenhardt, Mrs. Dennis S. . . . 3038 E. Fall Creek Blvd. (8)

Meiks, Mrs. Lyman T. . . . 4203 N. Pennsylvania St. (5)

Melin, Mrs. John R. . . . 4904 Olympia Dr. (8)
 Mericle, Mrs. Earl W. . . . 4480 N. Meridian St. (8)
 Merrell, Mrs. Paul. . . . 5367 Kenwood (8)
 Mertz, Mrs. John H. O. . . . 6950 Central Ave. (20)
 Michael, Mrs. Isaac E. . . . 3366 N. Kessler Blvd. (22)
 Miller, Mrs. Jack M. . . . 3336 Melbourne Rd. (8)
 Miller, Mrs. Jerry. . . . 6050 Ewing St. (20)
 Miller, Mrs. John D. . . . 6255 Sunnyside Rd. (26)
 Miller, Mrs. Roscoe E. . . . R. R. #17, Box 503 (23)
 Mitchell, Mrs. Earl N. . . . 1222 N. Irvington Ave. (19)
 Mitchell, Mrs. Edward O. . . . 4807 Millersville Rd. (26)
 Moenning, Mrs. John E. . . . 1905 N. King (22)
 Molt, Mrs. William F. . . . 2315 N. Talbot Ave. (5)
 Montgomery, Mrs. W. Foster. . . . 4546 Park Ave. (5)
 Moore, Mrs. Ben B. . . . 5005 N. Illinois St. (8)
 Moore, Mrs. Donald F. . . . 1315 West 10th Street (7)
 Moore, Mrs. Harold T. . . . 5802 Allisonville Rd. (20)
 Morchan, Mrs. Samuel. . . . 7007 Broadway (20)
 Morrison, Mrs. Lewis E., II. . . . 4450 Park Ave. (5)
 Morton, Mrs. Joseph L. . . . 3222 W. 42nd St. (8)
 Morton, Mrs. Walter P. . . . 3434 E. Fall Creek Blvd., N. Dr. (5)

Moser, Mrs. Rollin H. . . . 1840 W. 72nd St. (8)
 Moss, Mrs. H. C. . . . 410 E. 47th St.
 Mouser, Mrs. Robert W. . . . 6047 N. Meridian St. (20)
 Muller, Mrs. Lullus P. . . . 5608 College Ave. (20)
 Muller, Mrs. Paul F. . . . 4050 Washington Blvd. (5)
 Myers, Mrs. Roy V. . . . 4450 E. Kessler Blvd. (20)

N

Nafe, Mrs. Cleon A. . . . 5060 N. Meridian St. (8)
 Nagan, Mrs. Robert F. . . . 3902 Devon Dr. (18)
 Nay, Mrs. Richard M. . . . 5525 N. Meridian (8)
 Need, Mrs. Louis T. . . . 3627 Bluff Rd. (27)
 Nester, Miss Lena Laura . . . 5324 N. Pennsylvania St. (20)
 Nicholas, Mrs. Dennis. . . . 4365 Wexford Rd. (26)
 Nie, Mrs. Louis W. . . . 4305 Central Ave. (5)
 Nohl, Mrs. John M. . . . 5410 Eastridge Dr. (19)
 Nolin, Mrs. Richard T. . . . 6329 N. Michigan Rd. (18)

Nolting, Mrs. Henry F. . . . 155 W. Hampton Dr. (8)
 Norman, Mrs. William H. . . . 6416 Dean Road (20)
 Norris, Mrs. Max S. . . . 540 E. 36th (5)
 Nugent, Mrs. Edwin J. . . . 6840 N. Delaware St. (20)
 Nurnberger, Mrs. John I. . . . 5215 Washington Blvd. (20)

O

O'Brian, Mrs. Earl J. . . . 3425 West 57th Street (8)
 Ochsner, Mrs. Harold C. . . . 4565 Cold Spring Rd. (8)
 Offutt, Mrs. Andrew C. . . . 750 N. Campbell Ave. (19)
 Olvey, Mrs. Ottis N. . . . 5428 Central Ave. (20)
 Otten, Mrs. Claude F. . . . 5222 Washington Blvd. (20)
 Overley, Mrs. Ross A. . . . 2907 N. Warman (22)
 Owen, Mrs. John E. . . . 4429 N. Illinois St. (8)
 Owens, Mrs. Tracy C. . . . 2823 N. Meridian St. (8)

P

Pandolfo, Mrs. Harry. . . . 529 Markwood Ave. (27)
 Parker, Mrs. Burton. . . . 3315 W. 57th St. (8)
 Parks, Mrs. Herbert E. . . . 1008 N. Ritter (19)
 Parr, Mrs. Robert L. . . . 6229 Evanston Ave. (20)
 Patton, Mrs. Martin T. . . . 3060 N. Meridian, Apt. 504 (8)

Paulissen, Mrs. George T. . . . 741 Markwood (27)
 Paynter, Mrs. Morris B. . . . 115 Roberts Rd. (27)
 Pearson, Mrs. Lyman R. . . . 5215 N. Illinois St. (8)
 Peck, Mrs. Franklin B., Sr. . . . 3060 N. Meridian, #401 (8)

Peck, Mrs. Franklin B., Jr. . . . 8760 Carrollton Ave. (20)
 Peirce, Mrs. James D. . . . 3159 N. Pennsylvania St. (5)

Pennington, Mrs. Walter E. . . . 5727 Broadway Tr. (20)
 Permer, Mrs. Erwin. . . . 5590 Grandview Dr. (8)

Peters, Mrs. Robert J. D. . . . 3203 E. Michigan St. (1)
 Petranoff, Mrs. Theodore V. . . . 2814 Questend, S. Dr. (22)

Pfaff, Mrs. O. G. . . . 4605 N. Meridian St. (8)
 Phillips, Mrs. David L. . . . 8799 Washington Blvd., E. Dr. (20)

Pierce, Mrs. Emmett. . . . 223 E. 24th St. (5)
 Pickett, Mrs. Robert D. . . . 4713 Millersville Rd. (5)
 Pilcher, Mrs. Jack E. . . . 4601 Graceland Ave. (8)
 Pontius, Mrs. Edwin G. . . . 6221 Avalon Lane, E. Dr. (20)

Popplewell, Mrs. A. G. . . . 141 E. Southport Rd. (27)
 Price, Mrs. Francis W. . . . 550 East Edgewood Ave. (27)

Price, Mrs. James O. . . . 448 Wayside Dr., R. R. #14
 Pryor, Mrs. Richard C. . . . 6134 Carrollton Ave. (20)

R

Rabb, Mrs. Frank M. . . . 5117 Radnor Rd. (26)
 Raber, Mrs. Robert M. . . . 265 Williams Ct. (20)
 Rader, Mrs. George S. . . . 3778 E. 62nd St. (20)
 Rafalski, Mrs. Thomas A. . . . 3011 Sharon Ave. (22)
 Ragan, Mrs. William D. . . . 4633 Hinesley Ave. (8)
 Ramsey, Mrs. Frank B. . . . 1401 W. 52nd St. (8)
 Rapp, Mrs. George F. . . . 2644 Falcon Dr. (24)
 Reed, Miss Ann. . . . 4131 N. Meridian (8)
 Reed, Mrs. Phillip B. . . . 4131 N. Meridian St. (8)
 Rees, Mrs. Russell C. . . . 926 Ellenberger Pkwy., W. Dr. (19)

Reid, Mrs. Charles A. . . . 6506 Madison Ave. (26)
 Rhamy, Mrs. Robert K. . . . 2706 E. 65th St. (20)
 Rice, Mrs. Frederick A., Jr. . . . 5802 E. 46th St. (26)
 Rice, Mrs. Raymond M. . . . 7799 E. Holliday Drive (20)

Richardson, Mrs. Thad T. . . . 6126 E. St. Joseph St. (19)
 Ridolfo, Mrs. Anthony S. . . . 6139 Maren Dr. (24)

Robb, Mrs. John A. . . . 5151 N. Pennsylvania St. (5)
 Rochlin, Mrs. I. . . . 5005 Kenwood (8)
 Rogers, Mrs. Donald L. . . . 2618 Bluffwood Dr., W. (8)
 Roll, Mrs. John W. . . . 6340 Branshaw (26)
 Roller, Mrs. Charles W. . . . 2301 Garfield Dr. (3)

Romberger, Mrs. Floyd T., Jr. . . . 10 W. 64th St. (20)
 Rosenak, Mrs. Bernard D. . . . 5254 N. Delaware St. (20)

Ross, Mrs. Alexander T. 6050 Knyghton Rd. (20)
 Ruddell, Mrs. Karl R. 2626 N. Meridian St. (8)
 Ruddell, Mrs. Keith R. 1201 Golden Hill Drive (8)
 Rudesill, Mrs. Robert L. 5252 N. Capitol (8)
 Rust, Mrs. Byron K. 8120 Sycamore Rd. (20)
 Rust, Mrs. Roland B., Jr. 6640 Sunny Lane (26)
 Ryan, Mrs. Glenn V.
 3168 E. Fall Creek Pkwy., N. Dr. (5)

S

Sage, Mrs. Russell A. 8706 College Avenue (20)
 Salb, Mrs. Max C. 6741 Allisonville Rd. (20)
 Schaffer, Mrs. Edward V. 3785 E. 62nd St. (20)
 Schlegel, Mrs. Donald M. 6230 Dean Rd. (20)
 Schmoyer, Mrs. M. Ray. 7338 N. Audubon Rd. (20)
 Schneider, Mrs. Carl J. 340 N. Kenyon (19)
 Schuchman, Mrs. Gabriel. 5944 Central Ave. (20)
 Schuster, Mrs. Dwight. 4503 Washington Blvd. (5)
 Scofield, Mrs. John B. 9014 Pickwick (8)
 Scott, Mrs. George E. 4110 Roland Rd. (18)
 Scott, Mrs. Jasper P. 5840 Winthrop Ave. (20)
 Scott, Mrs. John R. 7966 N. Illinois St. (20)
 Scott, Mrs. Robert P. 5715 N. Pennsylvania (20)
 Seaman, Mrs. Charles F. 6017 Hillside, E. Dr. (20)
 Sedam, Mrs. Herbert L. 4819 Millersville Rd. (26)
 Segar, Mrs. William E. 4855 Victoria Rd. (8)
 Sellmer, Mrs. George W. 8765 Rosewood Lane (20)
 Sexson, Mrs. Hiram T. 5455 N. Meridian St. (8)
 Shafer, Mrs. Marion R. 6290 Allisonville Rd. (20)
 Sheehan, Mrs. Francis G.

 4260 Wanamaker Dr. (19)

Shipley, Mrs. Edward. 3601 Marrison Pl. (5)
 Shullenberger, Mrs. Wendell A.

 4535 Central Ave. (5)

Shumaker, Mrs. Harris B., Jr.

 4330 Central Ave. (5)

Sidebottom, Mrs. F. W. 2606 Bluffwood Dr., W. (8)
 Sicks, Mrs. Okla W. 5609 N. Pennsylvania St. (20)
 Siderys, Mrs. Harry. 3450 N. Lynhurst Dr. (24)
 Siebe, Mrs. Jack C. 5011 E. 40th St. (18)
 Siersdorfer, Mrs. T. N. 5559 W. Morris St. (41)
 Sigmond, Mrs. Harvey. 3245 N. Pennsylvania
 Silver, Mrs. Richard A. 7421 E. Frederick Dr. (8)
 Sims, Mrs. J. Lawrence. 3723 N. Gale St. (18)
 Sluss, Mrs. David. 3657 Washington Blvd. (5)
 Smith, Mrs. Edward B. 3322 Guilford Ave. (5)
 Smith, Mrs. E. Rogers. 160 W. 47th St. (8)
 Smith, Mrs. Roy Lee. R. R. 6, Box 232 (27)
 Snider, Mrs. Byron. 2717 S. East St. (3)
 Solomon, Mrs. R. A. 5330 N. Pennsylvania (20)
 Soper, Mrs. Hunter A. 5321 Boulevard Place (8)
 Southworth, Mrs. John W. 5002 W. 15th St. (24)
 Sovine, Mrs. Joe W. 8182 N. Illinois St. (20)
 Spahr, Mrs. John F., Jr.

 3014 Green Hills Lane, N. Dr. (22)

Spalding, Mrs. Joseph J. 7290 N. Meridian (8)
 Sparks, Mrs. Alan L. 5466 N. Pennsylvania St. (20)
 Spears, Mrs. John M. 5507 S. East St.
 Speckman, Mrs. Glenn H. 5342 Park Ave. (20)
 Sputh, Mrs. Carl B., Jr.

 5671 Rolling Ridge Rd. (20)

Stach, Mrs. Thomas W. 3927 Parker Ct. (5)
 Stansbury, Mrs. Wm. E. 5610 E. 16th St. (18)
 Stayton, Mrs. Chester A., Sr.

 6925 N. Delaware St. (20)

Stayton, Mrs. Chester A., Jr.

 7065 Central Ave. (20)

Steinmetz, Mrs. Edward. 5250 N. Delaware (20)
 Stephens, Mrs. Donald. 5555 Broadway (20)
 Stephens, Mrs. Kuhlman H.

 5210 Boy Scout Rd. (26)

Stoelting, Mrs. Vergil K. 4706 Laurel Circle (26)

Stone, Mrs. Alvin T. 5727 Broadway (20)

Storey, Mrs. D. Edmund

 808 Forest Blvd., N. Dr. (20)

Streeter, Mrs. Ralph. 5265 N. Meridian St. (8)

Strickland, Mrs. Neil R. 5117 E. 70th St. (20)

Stucky, Mrs. Elsworth K.

 4528 N. Meridian St. (8)

Stump, Mrs. Loyd K. 4250 Kessler Lane (20)

Sutton, Mrs. William E. 5670 Guilford Ave. (20)
 Swan, Mrs. John R. 320 Arden Dr. (20)

T

Talbott, Mrs. Dan E. 6470 N. Michigan Rd. (8)
 Tanner, Mrs. Henry S.

 4461 N. Pennsylvania St. (5)

Taylor, Mrs. Clifford C.

 3720 Briarwood Dr., E. (20)

Taylor, Mrs. Cyril. 4746 Jennys Rd. (8)

Taylor, Mrs. Frederick W. 40 E. 43rd St. (5)

Teague, Mrs. Frank W. 555 W. Pine Dr. (8)

Tether, Mrs. Joseph E., Jr.

 5735 N. Pennsylvania St. (20)

Tharpe, Mrs. Ray G. 6161 Sunset Lane (8)

Thatcher, Mrs. Hugh K., Jr. 408 E. 45th St. (5)

Thomas, Mrs. Charles R. 7029 Wayland Dr. (3)

Thomas, Mrs. Fred A. 3914 N. New Jersey St. (5)

Thomas, Mrs. Lowell I. 28 W. Hampton Dr. (8)

Thomas, Mrs. Morris E. 7215 Spring Mill Rd. (20)

Thompson, Mrs. John V. 7899 Ridge Rd. (20)

Thompson, Mrs. Wayne H. 6365 Knyghton Rd. (20)

Thornburg, Mrs. Kenneth E. 7306 N. Chester (5)

Throop, Mrs. Frank B.

 4030 N. Pennsylvania St. (5)

Thurston, Mrs. A. L. 4078 Central Ave. (5)

Tinsley, Mrs. Walter B. 3314 Carrollton Ave. (5)

Tinsley, Mrs. Walter B., Jr.

 4505 Melbourne Rd. (8)

Tischer, Mrs. E. Paul. 6801 Dean Rd. (20)

Tondra, Mrs. John M. 4511 Broadway (5)

Torrella, Mrs. Jose A. 5721 W. 18th St. (24)

Trusler, Mrs. Harold M.

 6150 N. Meridian St. (20)

Tuchman, Mrs. Joseph H. 8515 Spring View Dr.

Tucker, Mrs. Warren S.

 5338 N. Pennsylvania St. (20)

Tyler, Mrs. Edward. 5693 N. Meridian (20)

V

Van Meter, Mrs. C. Powell

 4102 Marrison Place (18)

VanOsdol, Mrs. Harry A. 43 W. Hampton Dr. (8)

Van Tassel, Mrs. C. J., Jr.

 5842 Washington Blvd. (20)

Vollrath, Mrs. Victor J. 5202 N. Illinois St. (8)

VonDerHaar, Mrs. Gerard

 1109 N. Mitchner St. (19)

Vore, Mrs. Robert B. 3710 Cheviot Place (5)

W

Waldo, Mrs. J. Thayer. 420 W. 64th St. (8)

Walther, Mrs. Joseph E.

 4266 N. Pennsylvania St. (5)

Walton, Mrs. William M. 5242 Boulevard Place (8)

Warriner, Mrs. James B. 990 N. Bolton Ave. (19)

Warvel, Mrs. John H.

 4360 Kessler Blvd., N. Dr. (8)

West, Mrs. Joseph L. 2110 W. 38th St. (8)

Westfall, Mrs. B. Kemper, Jr.

 4001 N. Meridian St. (8)

Westfall, Mrs. John B.

 5425 N. New Jersey St. (20)

Wheeler, Mrs. David E.

 5441 Brendonridge Rd. (26)

White, Mrs. Donald J. 5430 N. Delaware St. (20)

White, Mrs. Douglas H., Jr.

 6920 Munsee Lane (20)

White, Mrs. John B. 6425 Lawrence Dr. (26)

White, Mrs. Philip T. 5780 White Oak Ct.

Wilkens, Mrs. Irvin W.

 4820 E. Pleasant Run Pkwy., N. Dr. (1)

Williams, Mrs. Charles D. 160 E. 71st St. (20)

Williams, Mrs. Clifford L.

 Central St. Hospital (22)

Williams, Mrs. Howard S., Jr.

 3824 N. Delaware (5)

Williams, Mrs. Hugh L. 6231 Knyghton Rd. (20)

Willmore, Mrs. Ralph C. 6477 N. Tuxedo St. (20)

Wise, Mrs. William R. 1908 Orlando (8)

Wishard, Mrs. William N., Jr.
5720 N. Pennsylvania St. (20)
Witham, Mrs. Robert L. 5811 Ravine Rd. (20)
Wolfram, Mrs. Don J.

5716 N. Pennsylvania St. (20)
Wood, Mrs. Donald E. 6463 N. Illinois St. (20)
Woolling, Mrs. Kenneth R. 5751 Central Ave. (20)
Worley, Mrs. J. P. 6797 E. 10th (19)
Wrege, Mrs. Malcolm 6505 Riverview Dr. (20)
Wright, Mrs. J. Wm., Jr. 4220 Knollton Rd. (8)
Wytenbach, Mrs. John E. 5509 Kenwood Ave.

Y-Z

Yacko, Mrs. Michael L. 9740 E. 11th St. (19)
Young, Mrs. John E. 5920 Lawrence Dr. (20)
Young, Mrs. John M. 4535 Marcy Lane, No. 261 (5)
Zell, Mrs. Evertson H. 4747 Millersville Rd. (26)
Zerfas, Mrs. Charles P. A. R. 1, Box 220 (27)

New Augusta

Asher, Mrs. Ernest O. Box 6
Asher, Mrs. James W. 8381 Moore Rd.
Brown, Mrs. David E. 7344 Lakeside Dr., Box 178
Spivey, Mrs. Russell J.
5590 W. 79th St., R. 1, Box 542

Forbes, Mrs. Robert S. R. 1, Box 502, Camby
Kendrick, Mrs. William M. R. R. #1, Mooresville
Jones, Mrs. George L.

8933 Southeastern Ave., Wanamaker
Abreu, Mrs. Benedict E. R. R. 2, Zionsville
Schechter, Mrs. John S. 2560 E. 91st St., Carmel
Muller, Mrs. Victor H. R. R. 2, Box 441F, Carmel
Cuthbert, Mrs. Marvin P. R. R. 2, Box 386, Carmel
Hasewinkle, Mrs. Carroll W.

R. R. 2, Box 354, Carmel
Lefell, Mrs. James M. R. R. 2, Zionsville
Wilson, Mrs. Oliver R.

Box 259, R. R. 2, Morgantown
Ramage, Mrs. Walter F.

244 S. First St., Beech Grove
MacDougall, Mrs. John D.

R. R. 1, Box 170B, Westfield
Link, Mrs. Goethe R. 6, Box 152, Martinsville
Gaddy, Mrs. Euclid T. R. 2, Box 179, Plainfield

MARSHALL COUNTY

Hampton, Mrs. James Argos
Graham, Mrs. C. R. Bourbon
Bowen, Mrs. Otis R. 304 N. Center St., Bremen
Burkett, Mrs. Cecil Grant St., Bremen
Stine, Mrs. Marshall Shumaler Dr., Bremen

Plymouth

Coursey, Mrs. James R. R. 3
France, Mrs. Lloyd 617 Ferndale
Peterson, Mrs. Ronald 1805 Hope
Reed, Mrs. Robert G. 235 Hogarth
Rimel, Mrs. James F. 109 Bayless
Robertson, Mrs. James S. Center
Vore, Mrs. Loring W. Myers Lake, R. R. 4

MIAMI COUNTY

Shrock, Mrs. E. E. Amboy
Line, Mrs. Homer Chili
Herd, Mrs. Cloyn R. 16 Farview, Fairview
Rendel, Mrs. H. E. Mexico

Peru

Barnett, Helen 109 W. Seventh St.
Boone, Mrs. Max L. 301 Adams
Gutherie, Mrs. James U. 331 W. 3rd St.
Hill, Mrs. Lloyd 128 W. 5th St.
Johnson, Mrs. Owen 106 W. 6th St.
Malouf, Mrs. S. D. 359 W. Third St.
Snyder, Mrs. Parker S. 159 W. 6th St.
Wildman, Mrs. R. E. R. R. 2
Yarling, Mrs. Francis 117 E. Fifth St.

MONTGOMERY COUNTY**Crawfordsville**

Burks, Mrs. Jess E. 512 W. Wabash Ave.
Cornell, Mrs. Robert 1000 S. Washington
Daugherty, Mrs. Fred N. 415 W. Main St.
Eggers, Mrs. Richard R. 203 West St.
Fisher, Mrs. Frank L. 1801 Eastwood Dr.
Haller, Mrs. Thomas C. 508 W. Main St.
Humphreys, Mrs. John W. 1309 Durham Dr.
Kinnaman, Mrs. Howard A. R. R. 5
Kirtley, Mrs. James N. 615 Thornwood Road
Lingeman, Mrs. Byron J. 203 Wallace Ave.
Millis, Mrs. Samuel C. 201 Wallace Ave.
Peacock, Mrs. Norman F. 111 Wallace Ave.
Pierson, Mrs. Robert H. 305 E. Main
Richards, Mrs. Edgar E. Danville Rd., R. R.
Shannon, Mrs. Wesley E. 411 S. Walnut St.
Sharp, Mrs. John L. Waynetown Rd.
Wallace, Mrs. Hawthorne C. 107 W. Jefferson

Otten, Mrs. Ralph R. Darlington
Blix, Mrs. Fred Ladoga
Denny, Mrs. Frank T. Ladoga
Davis, Mrs. William H. New Market
Kindell, Mrs. Herschel D. New Richmond
Byrne, Mrs. Louis Roachdale
Rusk, Mrs. Hubert M. Wallace
Parker, Mrs. Carl B. Wingate

MORGAN COUNTY**Martinsville**

Brubeck, Mrs. James D. Martinsville
Eisenberg, Mrs. David 340 E. Cunningham
Gray, Mrs. Leon 260 N. Ohio
Miller, Mrs. Ray 290 E. Washington
Pitkin, Mrs. McKendree C. 440 E. Washington
Sweet, Mrs. Austin Martinsville
Van Wienan, Mrs. John 439 N. Jefferson
Willan, Mrs. Horace R. 109 S. Jefferson
Winter, Mrs. William 269 E. Green

Mooresville

Bivin, Mrs. J. H. N. Indiana Rd.
Comer, Mrs. C. W. R. R. 2
Comer, Mrs. Kenneth R. R. 2
Kendrick, Mrs. William M. Keller Hill Rd.
Van Bokkelen, Mrs. Robert W. 124 S. Indiana St.

Murphy, Mrs. M. G. R. R., Morgantown

OWEN-MONROE COUNTIES**Bloomington**

Austin, Mrs. D. C. 114 S. Grant
Borland, Mrs. Ray Moores Pike
Buckingham, Mrs. Richard E. 705 S. Fess
Creek, Mrs. Jean A. 2303 Fritz Dr.
DeMott, Mrs. Russell 904 S. Rose St.
Estes, Mrs. Ambrose 701 Highland St.
Fowler, Mrs. Richard R. Pleasant Ridge Road
Geiger, Mrs. Dillon D. 1704 N. Fee Lane
Hardtke, Mrs. Eldred F. 1400 Pickwick Place
Hepner, Mrs. H. S. 302 E. 7th St.
Holland, Mrs. D. J. 1100 Atwater
Holland, Mrs. Philip T. 1001 S. Jordan Ave.
Holtzman, Mrs. Paul W. 1203 Pickwick Pl.
Hrisomalos, Mrs. Frank 505 E. Kirkwood St.
Lundblad, Mrs. Wilfred M. 1880 Covenanter Dr.
Lyons, Mrs. Robert S. Walnut Rd.
Manifold, Mrs. Harold M. 1310 Nancy
Marchant, Mrs. Clarence 350 S. College
McIntire, Mrs. Clarence R. 2424 N. Dunn Rd.
Middleton, Mrs. Thomas O. 210 Gilbert Ave.
Milan, Mrs. Joseph F. 1312 Nancy
Miller, Mrs. John 1210 E. Wylie St.
Poolitsan, Mrs. George 1217 E. First St.
Quarles, Mrs. Edgar B. 811 Woodlawn St.

Ramsey, Mrs. Hugh S. 619 E. 1st St.
 Reed, Mrs. William C. 1215 Atwater Ave.
 Rogers, Mrs. Otto Floyd 804 E. 8th St.
 Smith, Mrs. Hershel S. 200 Glendora Dr.
 Smith, Mrs. Paul 819 N. College Ave.
 Stangle, Mrs. William 603 N. Fess
 Taraha, Mrs. Ralph 211 E. Martha Ave.
 Thomas, Mrs. Harry 129 S. Swain St.
 Topoligus, Mrs. James 1015 Atwater Ave.
 Wenzler, Mrs. Paul J. 150 Sunnyslopes Dr.
 Wilson, Mrs. T. L. Bender Road
 Winters, Mrs. Matthew 407 N. Park St.

Stouder, Mrs. C. E. Ellettsville
 Mitchell, Mrs. George L. Smithville
 Brown, Mrs. Marcel S. Spencer
 Smith, Mrs. Fred Spencer

PARKE-VERMILLION COUNTIES

Clinton

Evans, Mrs. F. J. 1315 S. Main St.
 Gerrish, Mrs. W. D. 125 S. 5th St.
 Herzberg, Mrs. Milton 545 S. Fourth St.
 Kercheval, Mrs. J. M. Box 192

Britton, Mrs. W. D. Bloomingdale Rd., Montezuma
 DeRenne, Mrs. W. L. 190 Market St., Newport

Rockville

Bloomer, Mrs. R. S. 502 W. York St.
 Harstad, Mrs. C. 515 W. High St.
 Kempf, Mrs. Gerald F. Ind. State Sanitarium
 Merrell, Mrs. Basil M. 516 S. Market St.

PERRY-SPENCER COUNTIES

Bush, Mrs. Hargis R. Sixth St., Cannelton
 Coultus, Mrs. Porter J. Bristow
 Glackman, Mrs. John C. 207 Center St., Rockport
 Gilbert, Mrs. Robert 411 E. 7th, Cannelton

Tell City

Dukes, Mrs. David A. 521 Main St.
 Glenn, Mrs. F. C. 436 Main St.
 Herr, Mrs. William Boyd Road
 James, Mrs. John Mark 24 11th St.
 James, Mrs. N. A. 740 Ninth St.
 Kemker, Mrs. Bernard P. 1717 13th St.
 Lally, Mrs. Edith 918 Main
 Lashley, Mrs. D. L. 606 Ninth St.
 Lohoff, Mrs. Lewis C. 425 10th St.
 Neifert, Mrs. Noel L. 1118 Blum St.
 Smith, Mrs. Fred, Jr. 1407 12th Street

PORTER COUNTY

Chesterton

Ashmore, Mrs. Herbert C. 317 Bowser
 Hall, Mrs. Thomas Dune Acres
 Harless, Mrs. C. M. 123 W. Indiana Ave.
 Reed, Mrs. John E. Wilson St.
 Robertson, Mrs. W. C. 600 E. Morgan

Valparaiso

Brown, Mrs. J. C. 458 Park Ave.
 Davis, Mrs. Carl 202 Indiana
 DeGrazia, Mrs. E. J. 410 Washington
 Douglas, Mrs. George R. 404 Washington
 Eades, Mrs. Ralph 203 Jefferson
 Frank, Mrs. John R. 303 Indiana
 Griffin, Mrs. Charles H. 362 McIntyre Ct.
 Koenig, Mrs. Robert 1804 Beulah Vista Dr.
 LaRocca, Mrs. Joseph 402 Erie
 Makovsky, Mrs. Theodore 1807 Beulah Vista Dr.
 O'Neill, Mrs. Martin J. 301 Washington
 Sacks, Mrs. Leonard Z. 563 Ravine Dr.
 Seipel, Mrs. Herman O. 302 Lafayette
 Vietzke, Mrs. Paul 102 Lafayette

PUTNAM COUNTY

Veach, Mrs. Richard L. Bainbridge
 Gray, Mrs. Clyde C. Cloverdale
 Ellet, Mrs. John D. Coatsville

Greencastle

Dettloff, Mrs. Frederick R. 300 Highfall Ave.
 Fuson, Mrs. W. J. 108 Northwood Blvd.
 Johnson, Mrs. James B. 314 Highfall Ave.
 Reigle, Mrs. Fredrick C. 509 Meadow Dr.
 Schauwecker, Mrs. Cleon M. 613 Ridge Ave.
 Smith, Mrs. Wm. R. F. D. 2
 Steele, Mrs. Dick J. 207 Northwood Blvd.
 Tennis, Mrs. George T. 605 S. Jackson
 Tipton, Mrs. William R. 103 Northwood Blvd.
 Wiseman, Mrs. V. Earle 6 Durham

RANDOLPH COUNTY

Farmland

Nixon, Mrs. Byron 312 N. Main
 White, Mrs. Harvey E. 200 S. Main

Harmon, Mrs. Wayne 113 Church St., Lynn
 Jordan, Mrs. Leo E. 209 W. Church, Lynn
 Shallenberger, Mrs. H. R. Modoc
 Potter, Mrs. Richard M. 120 W. Walnut, Ridgeville

Union City

Chambers, Mrs. Carol R. 1000 N. Columbia
 Chambers, Mrs. Leroy B. 800 N. Columbia
 Landon, Mrs. David L. 623 N. Columbia St.
 McClure, Mrs. Morris E. 702 Hickory St.
 Phipps, Mrs. Leland K. 516 N. Howard
 Reid, Mrs. Robert W. 706 W. Division
 Wagoner, Mrs. B. D. 409 N. Columbia St.

Winchester

Engle, Mrs. Russell B. R. R. 2
 Koch, Mrs. Howard W. Franklin St.
 Painter, Mrs. Lowell W. 507 S. Main
 Slick, Mrs. C. R. 512 S. Oak Street
 Sparks, Mrs. Paul W. 601 W. Will
 Spitler, Mrs. C. A. R. R. #4

RIPLEY COUNTY

Freeland, Mrs. Bill. 714 Edgewood Rd., Batesville
 Hisrich, Mrs. L. W. 222 Maplewood, Batesville
 Lippoldt, Mrs. Chas. L. Edgewood Rd., Batesville
 Warn, Mrs. William Milan
 Row, Mrs. George R. R. 3, Osgood
 Smith, Mrs. Lee R. Osgood
 McConnell, Mrs. William C. Sunman
 Moran, Mrs. N. D. Versailles

RUSH COUNTY

McNabb, Mrs. George B. Carthage
 Worth, Mrs. C. Willard Milroy

Rushville

Atkins, Mrs. C. C. 410 N. Perkins
 Corpe, Mrs. Kenneth F. R. R. 4
 Deerhake, Mrs. William A. 501 N. Harrison
 Denny, Mrs. Melvin R. R. #1
 Ellis, Mrs. Davis W. 721 N. Perkins
 Green, Mrs. Frank H. 516 N. Morgan
 Hoover, Mrs. Eugene 501 N. Harrison
 McKee, Mrs. Harry S. R. R. 6
 Norris, Mrs. Marvin 1107 N. Main St.
 Shanks, Mrs. Roy E. 1110 N. Morgan
 Smith, Mrs. Stephen D. 4 Maple Dr., Knightstown

SHELBY COUNTY

Nigh, Mrs. R. M. Fairland
Davis, Mrs. John A. Flat Rock

Shelbyville

Arata, Mrs. Lucian A. 327 W. Broadway
Dalton, Mrs. Wilson L. 1712 Culbertson
Gehres, Mrs. Robert W. 610 Shelby
Grove, Mrs. E. G. 242 W. Broadway
Inlow, Mrs. Herbert H. 212 N. Harrison
Inlow, Mrs. W. D. Spring Hill Rd.
McFadden, Miss Marian. 28 W. Mechanic St.
McFadden, Mrs. Walter C. 28 W. Mechanic
Miller, Mrs. R. C. 17 W. Mechanic
Moheban, Mrs. Joseph. 324 Shelby
Phares, Miss Frances. 408 S. Harrison
Richard, Mrs. Norman F. 541 Lockerbie Rd.
Scott, Mrs. V. B. R. R. 2, N. Riley Hwy.
Silbert, Mrs. David B. 1100 Fairfield Drive
Spindler, Mrs. Robert D. 165 W. Mechanic
Tindall, Mrs. Paul R. 164 W. Franklin
Tindall, Mrs. W. R. 616 S. Harrison
Tower, Mrs. James H., Jr. 1018 S. West Street
Whitcomb, Mrs. Roger F. 218 W. Broadway

ST. JOSEPH COUNTY

Mishawaka

Fujawa, Mrs. M. J. 721 Lincoln Way E.
Martin, Mrs. Chas. F., Jr. 2125 Linden Ave.
Barone, Mrs. C. V. 59053 Bremen Highway
Ganser, Mrs. Ralph. 1035 Lincolnway E.
Ganser, Mrs. Richard A. 1020 Wilson Blvd.
Goethals, Mrs. C. J. 602 Lincolnway W.
McDonald, Mrs. R. M. 12252 E. Jefferson Road
Orr, Mrs. Robert. 1335 Prospect Dr.
Reed, Mrs. Robert. 903 Homewood
Sirlin, Mrs. Edward M. 14736 Jefferson Rd.
Spalding, Mrs. Wendell L. 60100 So. Fir Road
Templeton, Mrs. Ames R. 522 Calhoun St.
Walerko, Mrs. Frank M. 515 N. Clay St.
Walters, Mrs. Charles E. 16166 Ireland Rd.
Whitlock, Mrs. Francis. 304 Lincoln Way E.
Whitlock, Mrs. Merle E. 16146 Chandler Blvd.
Wurster, Mrs. H. C. 221 E. Third St.
Wyland, Mrs. B. J. 510 Calhoun St.
Zimmer, Mrs. H. J. 333 Edgewater Dr.

Houser, Mrs. D. S.
24751 N. Riley Rd., North Liberty

South Bend

A

Acker, Mrs. Robert B. 103 S. Ironwood Dr.
Arisman, Mrs. R. K. 1615 E. Colfax Ave.

B

Backs, Mrs. Alton J. 1953 Inglewood Place
Balla, Mrs. Morris. 1516 S. 20th St.
Baran, Mrs. Charles. 1808 E. Jefferson Blvd.
Bartsch, Mrs. Harvey L. 61397 S. Miami Rd.
Bechtold, Mrs. S. E. 313 Pendle St.
Bell, Mrs. H. D. 1357 Champeau St.
Bennett, Mrs. Jene R. 1826 E. Jefferson Blvd.
Berke, Mrs. Robert D. 2510 Erskine Blvd.
Biasini, Mrs. B. A. 19585 Glendale Road
Bickel, Mrs. David A. 1335 E. Wayne St. N.
Birmingham, Mrs. P. J. 1126 E. Irvington
Bishop, Mrs. C. Allen. 1301 Garland Rd.
Bixler, Mrs. Louis C. 1817 Portage Ave.
Bodnar, Mrs. Leslie M. 1843 Portage Ave.
Bogan, Mrs. Wm. C. 1512 Hass Dr.
Borough, Mrs. Lester D. 816 E. Woodside

Brecht, Mrs. H. J. 2305 E. Washington
Buchanan, Mrs. Wallace D. 1326 E. Wayne St., N.
Buechner, Mrs. Fred W. 603 W. Marion St.
Buslee, Mrs. Roger M. 1331 E. South St.
Bussard, Mrs. Frank. 1311 Sunnymede Ave.
Butts, Mrs. Milton. 118 N. Walnut St.

C

Carter, Mrs. F. R. N. 2000 E. Jefferson Blvd.
Cassady, Mrs. John R. 1805 Marquette Blvd.
Chamblee, Mrs. R. W. 1435 Corby Blvd.
Clark, Mrs. W. H. 1227 Garland Rd.
Colip, Mrs. George D. 260 David St.
Condit, Mrs. D. H. 1521 E. Wayne St.
Cook, Mrs. Gordon C. 1620 Southwood Ave.
Custer, Mrs. Edward W. 52383 Laurel Road

D

Davis, Mrs. Edward A. 2610 Lincoln Way W.
Denham, Mrs. Robert H. Jr. 1429 E. Wayne St.
DeVoe, Mrs. K. R. 621 Woodcliff Dr.
Dingley, Mrs. Albert F. 1976 Briar Way
Dodd, Mrs. Robert D. 1510 Tudor Lane
Dolezal, Mrs. Bernard J. 815 Park Ave.
Duggan, Mrs. James A. 110 Peashway
Dunlap, Mrs. D. Logan. 123 North Shore Dr.

E

Eades, Mrs. R. Charles. 232 Marquette Ave.
Edwards, Mrs. Bernard E. 1340 Garland Rd.
Egan, Mrs. Sherman L. 944 Riverside Dr.
English, Mrs. J. Paul. 3116 Robinhood Lane
Eriksen, Mrs. L. G. 1212 E. Woodside
Erickson, Mrs. G. Walter. 3012 Robinhood Lane

F

Feferman, Mrs. Martin E. 125 S. Esther St.
Feldman, Mrs. Max. 702 N. Lafayette Blvd.
Filipek, Mrs. Walter. 2513 Lincoln Way West
Firestein, Mrs. Ben Z. 125 W. Marion Street
Fish, Mrs. Edson C. 19054 Summers Drive
Frank, Mrs. Herbert. 2616 S. Twyckenham Dr.
Frank, Mrs. L. L. 534 N. Lafayette Blvd.
Frank, Mrs. L. L., Jr. 1750 N. Wilbur
Frash, Mrs. D. W. 1912 Miami Street
Friedman, Mrs. Morris S. 1617 E. Jefferson Blvd.

G

Gates, Mrs. George E. 411 W. North Shore Dr.
Gilman, Mrs. Marcus. 1925 E. Jefferson Blvd.
Godersky, Mrs. George. 2744 Sampson St.
Goraczewski, Mrs. T. C. 1016 W. Washington
Graf, Mrs. John F. 424 Peashway
Green, Mrs. George F. 1515 E. Wayne St.
Green, Mrs. Norvel E. 1726 E. LaSalle Ave.
Grove, Mrs. James H. 60268 Mayflower Rd.

H

Hamilton, Mrs. Charles O.
1418 E. Washington Ave.
Haugseth, Mrs. E. K. 820 N. Ironwood
Hawkins, Mrs. Glen E. 17280 Parker Ave.
Helmer, Mrs. John. 1825 Wilbur St.
Hildebrand, Mrs. J. O. 1637 Southbrook Dr.
Hill, Mrs. Theodore. 107 N. Eddy St.
Hill, Mrs. Wallace C. 1221 Sunnymede Ave.
Hillman, Mrs. Marion W. 1516 Marquette Blvd.
Holdeman, Mrs. Lillian S. 615 W. Colfax Avenue
Holtzman, Mrs. Norman. 3322 Whitcomb
Hyde, Mrs. C. C. 1521 E. Colfax Ave.

K

Kamm, Mrs. Bernard A. 125 W. Marion St.
Karn, Mrs. John W. 1535 Wall St.
Krueger, Mrs. John E. 620 Peashway
Kuhn, Mrs. Frederick L. 1215 S. Michigan St.

L

Lamb, Mrs. Leonard J. 1321 E. Wayne St., South Lane, Mrs. William H. 845 Park Ave.
 Lester, Mrs. Vern L. 2819 Woodmont
 Levatin, Mrs. B. 1814 E. Churchill Dr.
 Levkoff, Mrs. Abner 3239 Essex Dr.
 Lionberger, Mrs. John R. 1419 E. Jefferson Blvd.
 Liss, Mrs. Emanuel Apt. B.52112-20 72nd Dr., Forest Hills 75, New York
 Lockhart, Mrs. Philip B. 1611 E. Wayne

M

MacLeod, Mrs. John K. 930 Simmon Ct.
 Mahank, Mrs. Camiel C. 1804 E. Jefferson
 Marquis, Mrs. Gordon 329 Wakewa
 Mason, Mrs. Bernard A. 2719 Marine St.
 Mauzy, Mrs. Merritt 1740 Hass Dr.
 Metcalfe, Mrs. G. E. 1209 E. Wayne, No.
 Miller, Mrs. Milo K. 1018 E. Oakside
 Mott, Mrs. C. A. 2733 Lincolnway West
 Mueller, Mrs. H. M. 3525 Windingwood Dr.
 Murphy, Mrs. Eugene C. 1411 Sunnymede Ave.

N-O

Neker, Mrs. John L. 17371 Cleveland Rd.
 Nelson, Mrs. Raymond E. 1909 E. Madison St.
 Olson, Mrs. Donald T. 127 S. Ellsworth Pl.
 Olson, Mrs. Kenneth L. 1228 E. Woodside Ave.
 Oren, Mrs. William 1149 E. Belmont

P

Parsons, Mrs. Robert 1464 Ridgedale Rd.
 Pauszek, Mrs. Thomas B. 916 Riverside Dr.
 Petrass, Mrs. Andrew 22027 Liberty Highway
 Plain, Mrs. George 17836 Ponader Drive
 Pyle, Mrs. H. Dale 115 N. Sunnyside Ave.

R

Rigley, Mrs. Edward L. 1704 Ridgedale Rd.
 Roberts, Mrs. Billy J. 1523 Crestwood Blvd.
 Rosenheimer, Mrs. George M. 1425 E. Woodside
 Rubens, Mrs. Eli 1240 E. Irvington

S

Sanderson, Mrs. Robert B. 1331 Sunnymede Ave.
 Sandock, Mrs. I. 1203 N. Notre Dame Ave.
 Sandock, Mrs. Louis E. 235 S. Esther St.
 Sandoz, Mrs. H. H. 239 S. Hawthorne Dr.
 Sandoz, Mrs. Louis A. 304 S. Twyckenham Dr.
 Schiller, Mrs. Herbert A. 1813 E. Cedar St.
 Scott, Mrs. Frank M. 1220 E. Woodside
 Selby, Mrs. K. E. 1327 E. Wayne, No.
 Sellers, Mrs. Francis 3209 Mishawaka Ave.
 Sensenich, Mrs. R. L. 128 S. Scott St.
 Sharp, Mrs. Merle C. 17772 Woodthrush Lane
 Sisson, Mrs. Norval D. 1614 Oak Park Dr.
 Skillern, Mrs. Scott 1553 Southbrook Dr.
 Slominski, Mrs. Harry H. 1862 College St.
 Spenner, Mrs. R. W. R. R. #3, Diamond Lake
 Staunton, Mrs. Henry A. 124 S. 34th St.
 Stiver, Mrs. Dan D. 1127 E. Wayne St. N.
 Stogdill, Mrs. William 520 N. Coquillard

T

Thompson, Mrs. John M. 1618 E. Cedar St.
 Thornton, Mrs. M. J. R. R. #2, Miami Rd.
 Tirman, Mrs. Wallace S. 1224 E. Wayne St., No.

V-W-Z

Vagner, Mrs. S. Bernard 53190 Willow Run Road
 Walker, Mrs. Edwin M., Jr. 501 N. Ironwood
 Ward, Mrs. James 19248 Summers Dr.

Weiss, Mrs. Eugene 1605 E. Washington Ave.
 White, Mrs. Donald G. 1721 E. Altgeld
 Wilson, Mrs. James M. 1416 E. Monroe St.
 Zeiger, Mrs. Irwin L. 1205 E. Irvington

STARKE COUNTY

DeNaut, Mrs. J. F. 4 N. Heaton, Knox
 Howard, Mrs. Henry 308 W. New York, Knox
 Ingwell, Mrs. Guy B. 402 E. Lake, Knox
 Leinbach, Mrs. Earl R. 206 Davis, Hamlet
 Matthew, Mrs. J. R. 605 Keller Ave., North Judson
 McClure, Mrs. Clark R. R. 1, Knox

TIPPECANOE-WHITE COUNTIES

Lafayette

Babb, Mrs. Forrest J. 2106 South 9th St.
 Baker, Mrs. John R. 1603 Potomac
 Bayley, Mrs. Richard D. 725 S. 11th St.
 Buhrmester, Mrs. Harry C. Freiberger Lane
 Canganelli, Mrs. Vincent G. 2310 N. River Rd.
 Carpenter, Mrs. John B. 1720 Scott St.
 Dubois, Mrs. Ramon B. 519 Calvert Lane
 Fields, Mrs. Donald C. R. R. 3
 Frey, Mrs. Harley H. 505 Calvert Lane
 Graham, Mrs. Thomas G. 1213 Wea Ave.
 Gripe, Mrs. Richard P. 1623 S. Fifth St.
 Harter, Mrs. Eli B. 918 King St.
 Holladay, Mrs. L. J. 1403 S. 14th St.
 Johnson, Mrs. Herbert S. 712 Cherokee
 Jones, Mrs. David 2055 S. Ninth St.
 Karberg, Mrs. Richard J. 1212 El Prado
 Klepinger, Mrs. Harry E. 909 N. 21st St.
 Kohne, Mrs. Robert W. 1001 Pontiac
 Landis, Mrs. C. Byron 70 Collins Dr.
 Marvel, Mrs. Howard R. 1106 Hedgewood Dr.
 McAdams, Mrs. Hugh B. 2110 Birch Lane
 McClelland, Mrs. D. C. 1021 Highland Ave.
 McKinley, Mrs. Joseph 610 Lingle Terrace
 Neumann, Mrs. Kenneth O. 1410 S. 18th St.
 Onorato, Mrs. Joseph 2606 South St.
 Ratcliff, Mrs. Frank W. 1000 Wea Ave
 Rothrock, Mrs. Philip W. 605 Lingle Ave.
 Shively, Mrs. John L. 1615 S. 5th St.
 Sholty, Mrs. William M. Shadeland Farm Rd.
 Trout, Mrs. Carl J. 800 State St.
 Underwood, Mrs. George M. 2540 Lafayette Dr.
 VanReed, Mrs. Earl 806 S. 9th St.
 Vermilya, Mrs. Robert W. R. R. 5, Cedar Bluff Rd.
 Williams, Mrs. Robert E. 403 Asher

West Lafayette

Bayley, Mrs. William 622 Rose St.
 Bolin, Mrs. Robert C. 908 Windsor Dr.
 Burns, Mrs. John T. 2201 N. Salisbury St.
 Calvert, Mrs. R. R. 308 Park Lane
 Combs, Mrs. Loyal W. 514 Rose St.
 Davis, Mrs. Howard B. 833 Hillcrest Rd.
 Eaton, Mrs. Marion J. 425 Forest Hills Dr.
 Elliott, Mrs. Paul W. 348 W. Stadium
 Engeler, Mrs. James E. 1316 N. Grant St.
 Ferguson, Mrs. William B. 430 Forest Hills Dr.
 Harden, Mrs. Murray E. 168 Creighton Rd.
 Hogle, Mrs. Frank D. 334 Laurel Dr.
 Hughes, Mrs. Richard R. 908 Carrollton Blvd.
 Hull, Mrs. James E. 605 Carrollton Blvd.
 Johnson, Mrs. Lowell R. 1601 Woodland Dr.
 Klatch, Mrs. Ben Z. 1415 Woodland Dr.
 Loop, Mrs. Frederick A. 119 Leslie Dr.
 Marsh, Mrs. George W. 2121 Happy Hollow Rd.
 McAdams, Mrs. Robert 625 Ridgewood
 McFadden, Mrs. James M. 1424 N. Salisbury
 Mather, Mrs. Charles R. 1815 Ravinia Rd.
 Mather, Mrs. Robert L. 321 Leslie Ave.
 Miller, Mrs. Roland E. 600 Ridgewood Dr.

Mount, Mrs. William M.....217 Pawnee Dr.
 Peyton, Mrs. Frank W.....612 Ridgewood Dr.
 Stahl, Mrs. E. T.....324 Park Lane
 Steele, Mrs. Hugh H.....118 Sunset Lane
 Stuntz, Mrs. Edgar C.....271 E. Sunset Lane
 VanDen Bosch, Mrs. W. R.....715 Princess Dr.
 Washburn, Mrs. William W...209 Forest Hills Dr.
 Weaver, Mrs. Richard J.....1504 N. Grant
 Williams, Mrs. Russell S.....212 Indiana Trail Dr.

Lind, Mrs. Jaap J.....Mulberry
 Weller, Mrs. Ralph.....Rossville

VANDERBURGH COUNTY

(Southwestern)

Stover, Mrs. Wendell C.
 20 Lake Shore Dr., Boonville

Evansville

A

Acre, Mrs. Robert R.....2311 Lincoln Ave.
 Adler, Mrs. Ray N.....1660 Lincoln Ave.
 Adye, Mrs. Wallace M.....320 Inwood Dr.
 Alexander, Mrs. John E.....1105 S. E. First
 Antes, Mrs. Earl H.....1201 Bonnieview Dr.
 Arendell, Mrs. Robert E.....710 S. Weinbach Ave.
 Austin, Mrs. Eugene W.....2163 Bayard Park Dr.

B

Baker, Mrs. Mason R.....4500 E. Cherry St.
 Barnhart, Mrs. Willard T.....507 S. Boeke Rd.
 Beck, Mrs. Robert E.....6000 Newburgh Rd.
 Bender, Mrs. Martin J.....2716 Capitol Blvd.
 Bennett, Mrs. Abner P.....961 Blue Ridge Rd.
 Bissonette, Mrs. Roger P.....911 Colony Rd.
 Boone, Mrs. Robert D.....7501 E. Chandler Ave.
 Brakel, Mrs. Frank, Jr.....1849 McConnell Ave.
 Britt, Mrs. Robert L.....6416 Arcadian Hwy.
 Brockmole, Mrs. Arnold W.
 5901 New Harmony Rd.

Brown, Mrs. George W.....2051 E. Florida St.
 Bryan, Mrs. Stanton L.....3211 E. Mulberry St.
 Buehner, Mrs. Donald F.....1200 Bonnieview Dr.
 Burger, Mrs. Thomas C....2331 Washington Ave.
 Burnikel, Mrs. Ray H....960 S. Rotherwood Ave.
 Burress, Mrs. Clyde.....10100 Old St. Rd.

C

Cacia, Mrs. John J.....420 S. Boeke Rd.
 Caldwell, Mrs. William C.....643 College Hwy.
 Carlson, Mrs. Ralph F.....1350 Bayard Park Dr.
 Clark, Mrs. Thomas W.....810 Plasa Dr.
 Clouse, Mrs. Paul A.....2066 Bayard Park Dr.
 Cockrum, Mrs. William M.....1414 Parkside Dr.
 Coleman, Mrs. Joseph E.....2831 Wayside Dr.
 Cooper, Mrs. Wallace.....4410 Oak St.
 Corcoran, Mrs. P. J. V.....2412 E. Chandler Ave.
 Crawford, Mrs. James...631 Blue Ridge Dr. North
 Crevello, Mrs. Albert J.....1664 Lincoln Ave.
 Crimm, Mrs. Paul D.....Boehne Hospital
 Cuff, Mrs. Steve.....2921 Wayside Dr.
 Cullnane, Mrs. Chris W....3020 Mt. Vernon Ave.
 Cymbala, Mrs. Bohden.....1141 Bayard Pk. Dr.

D

Daves, Mrs. W. Lawrence.....708 College Hwy.
 Davidson, Mrs. Harold H....800 Blue Ridge Rd.
 Deems, Mrs. Myers.....6830 Arcadian Highway
 Denzer, Mrs. Edward K.....540 Scenic Dr.
 Denzer, Mrs. William O.....923 Bellemeade
 Dieckman, Mrs. Herbert S.....Johnson Place
 Dodd, Mrs. R. K.....1705 S. New Green River Rd.

Dunham, Mrs. Howard.....3215 Ridge Top Place
 Dycus, Mrs. Walter A.....3400 Koring Rd.
 Dyer, Mrs. Wallace K.....812 St. James Blvd.

E

Engel, Mrs. Edgar L.....1411 E. Park Dr.

F

Faith, Mrs. Ira L., Jr.....950 Blue Ridge Road
 Faul, Mrs. Henry.....725 S. Willow Rd.
 Faw, Mrs. Melvin J.....3105 E. Oak Street
 Fenneman, Mrs. Robert J.

Box 202A, R. R. 8, Old St. Rd.

Fisher, Mrs. William C.....1319 S. Kentucky
 FitzGerald, Mrs. Maurice D..924 Bayard Park Dr.
 Fitzsimmons, Mrs. Elvin L.....500 S. Boeke Rd.

G

Garland, Mrs. Edger A.....719 Plaza Dr.
 Gaul, Mrs. L. Edward.....508 S. Boeke Rd.
 Getty, Mrs. William H.....1810 Mt. Auburn Road
 Giorgio, Mrs. Douglas J.....916 S. Burkhardt Road
 Griep, Mrs. Arthur H.....5414 Madison Ave.
 Guckien, Mrs. Joseph L.....1612 S. E. Blvd.

H

Hammond, Mrs. R. Case.....6820 Arcadian Hwy.
 Hare, Mrs. Daniel M.....2112 Lincoln
 Harlan, Mrs. Wiliam.....4 Woodmere Dr.
 Harned, Mrs. Ben King, Jr.....8232 Maple Lane
 Hart, Mrs. Paul L.....1436 Lincoln Ave.
 Hartley, Mrs. Clarence A., Jr....300 Hesmer Rd.
 Heinrich, Mrs. Weston A.....1408 Lincoln Ave.
 Hendershot, Mrs. Eugene L..7006 Newburgh Road
 Hermayer, Mrs. Stephen.....1316 Bonnieview Dr.
 Herrmann, Mrs. Gordon T.....218 S. Spring St.
 Herzer, Mrs. Clarence C.....211 E. Mill Rd.
 Himebaugh, Mrs. Gilbert J.....408 S. Alvord Blvd.
 Hoover, Mrs. Guy J.....864 Lodge Ave.
 Hovda, Mrs. Richard B.....800 St. James Blvd.
 Huggins, Mrs. Victor S.....520 S. Alvord Blvd.
 Hyatt, Mrs. Gilbert T.....1616 Mt. Auburn Rd.

J-K

Johnson, Mrs. Stephen L.....2215 Lincoln Ave.
 Johnson, Mrs. Victor.....1303 Masker Pk. Dr.
 Kelly, Mrs. John B.....9130 Petersburg Rd.
 Kiechle, Mrs. Fred L.....726 S. E. First St.
 Kincaid, Mrs. Robert S.....1000 N. Spring St.

L

Laubscher, Mrs. Clarence A....6621 Kratzville Rd.
 Lawrence, Mrs. Joseph C..1362 E. Chandler Ave.
 Leibundguth, Mrs. Henry.....5206 Lincoln Ave.
 Leslie, Mrs. Ermil T.....3214 E. Mulberry St.
 Lewis, Mrs. Earl T.....1611 Jackson Ave.
 Logan, Mrs. Jesse R.....503 First Ave.

M

MacKenzie, Mrs. Pierce.....2300 E. Gum St.
 Mathews, Mrs. James R.....901 Meadow Rd.
 Maxson, Mrs. Roy V.....763 S. Weinbach Ave.
 Mayberry, Mrs. Alton R....6125 Washington Ave.
 McCool, Mrs. Joe H.....6314 Old State Rd.
 McDonald, Mrs. J. D.....4300 Lincoln Ave.
 Mehl, Mrs. Rudolph A.....631 Blue Ridge Dr.
 Meyer, Mrs. Keith T.....399 S. Alvord Blvd.
 Miller, Mrs. LaVerne B.....501 Scenic Drive
 Miller, Mrs. Milton J.....8201 Newburgh Rd.
 Miller, Mrs. Minor W.....701 S. Weinbach Ave.
 Mills, Mrs. Fred E.....555 S. Kelsey Ave.
 Mino, Mrs. Robert A.....2777 Wayside Dr.
 Moehlenkamp, Mrs. Charles E.
 5401 Stringtown Rd.
 Murphy, Mrs. Edward U....7 W. Buena Vista Rd.

N

Nicholson, Mrs. Raymond W....2009 Mahrendale
 Niedermayer, Mrs. Alfred J....815 College Hwy.
 Nonte, Mrs. Lee R.....714 S. Willow Rd.

O

Oswald, Mrs. Robert H.... 762 St. James Blvd.

P

Pastor, Mrs. J. W.....5901 Washington Ave.
 Pemberton, Mrs. Jack James..Falstead Rd., R. R. 1
 Pollard, Mrs. Walter S.....1230 S. E. Second St.
 Porre, Mrs. Francis W.....909 Villa Dr.
 Present, Mrs. Julian D.....201 Parker Dr.
 Pugh, Mrs. Willis L.....5204 Lincoln Ave.

R

Ratcliffe, Mrs. Albert W.....510 S. E. First St.
 Reich, Mrs. Clarence E.....1209 N. Fulton Ave.
 Richey, Mrs. Clifford O.....407 Congress Ave.
 Rietman, Mrs. H. Jerome.....2325 Lincoln Ave.
 Rininger, Mrs. Harold C.....2154 E. Gum St.
 Ritchie, Mrs. William D.....5201 Stringtown Rd.
 Rittlemeyer, Mrs. Louis.....Hogue Rd., R. R. 13
 Ritz, Mrs. Albert.....2004 Lincoln Ave.
 Rosenblatt, Mrs. Bernard B....626 St. James Blvd.
 Royster, Mrs. Robert Allen....34 Johnson Place
 Rusche, Mrs. Henry J.....315 W. Iowa St.
 Russell, Mrs. Richard H.....1015 Harrelton Ct.

S

Schimmelpennig, Mrs. Robert W.
 3014 Washington Ave.
 Schirmer, Mrs. Robert H.....2710 Hartmetz Ave.
 Schneider, Mrs. Charles P....2924 W. Maryland St.
 Schriefer, Mrs. Victor V.....390 S. Alvord Blvd.
 Sinn, Mrs. Charles M.....1509 Redwing Dr.
 Slaughter, Mrs. Howard C.....651 St. Mary's Dr.
 Slaughter, Mrs. John C.....622 College Hwy.
 Slaughter, Mrs. Owen L.....506 St. James Blvd. So.
 Smith, Mrs. Roy M.....3213 Kensington
 Sprecher, Mrs. Herman C....6601 Newburgh Road
 Springstun, Mrs. W. Russel....854 Lodge Ave.
 Steele, Mrs. Paul W.....1906 Bellemeade Ave.
 Sterne, Mrs. John H.....2309 E. Gum St.
 Stork, Mrs. Urban F. D.....414 S. Kelsey Ave.
 Strueh, Mrs. Paul E.....1207 Harrelton Ct.

T

Tager, Mrs. Stephen H.....700 S. Meadow Rd.
 Tisserand, Mrs. John B. Jr..637 College Highway
 Tuholski, Mrs. James M.....520 S. Roosevelt Dr.
 Tweedall, Mrs. Daniel G.....900 S. Meadow Rd.

V-W

Visher, Mrs. John W.....510 E. Mt. Pleasant Rd.
 Vonder Haar, Mrs. Thomas E....1152 S. Villa Dr.
 Walker, Mrs. William F.....1220 Cullen Ave.
 Walter, Mrs. Robert F.....1514 S. Kentucky Ave.
 Warner, Mrs. Charles L.....4120 Bellemeade Ave.
 Waters, Mrs. George E.....2 Woodmere Dr.
 Weber, Mrs. Edgar H.....3008 E. Powell Ave.
 Weiss, Mrs. H. G.....1014 E. Powell Ave.
 Welborn, Mrs. Mell B.....1832 Mt. Auburn Rd.
 Wilhelmus, Mrs. C. Kenneth..6929 Newburgh Rd.
 Wilhelmus, Mrs. Gilbert M....5901 Newburgh Rd.
 Willison, Mrs. George W.....605 St. Mary's Dr.
 Wilson, Mrs. John D.....921 Colony Rd.
 Wilson, Mrs. David.....1709 S. E. Blvd.
 Wilson, Mrs. Ralph.....1522 Audubon Dr.
 Wynn, Mrs. Justice F.....651 S. Weinbach Ave.

Y-Z

Young, Mrs. C. Curtis, Jr.....2327 Lincoln Ave.
 Zeier, Mrs. Francis G.....3708 Mulberry
 Zimmerman, Mrs. Harold.....513 S. Boeke Rd.

Challman, Mrs. William..502 Walnut, Mt. Vernon
 Crist, Mrs. John R.....320 Emmick, Mt. Vernon
 Hirsch, Mrs. H. L....801 Williams Dr., Mt. Vernon
 Oliphant, Mrs. Frank W.

701 Mulberry St., Mt. Vernon
 Vogel, Mrs. John L....530 E. Fifth St., Mt. Vernon
 Colvin, Mrs. Robert C....Peachtree St., Newburg
 Durkee, Mrs. Melvin S.

Ideal Pleasure Club, Newburgh
 Zwickel, Mrs. R. E.....Darby Hills, Newburgh
 Ropp, Mrs. Harold E....Church St., New Harmony

VIGO COUNTY

Speas, Mrs. Robert C.....Box 22, Seelyville

Terre Haute

A

Anderson, Mrs. W. C.....380 S. 22nd St.
 Ault, Mrs. Roy J.....926 Barton Avenue

B

Baldrige, Mrs. William O.....2500 N. Ninth St.
 Bannon, Mrs. William G.....2126 Ohio Blvd.
 Benages, Mrs. Anthony G.....2224 Ohio Blvd.
 Blum, Mrs. Leon L.....3200 Ohio Blvd.
 Bopp, Mrs. Henry W., Sr.....132 Barton Ave.
 Bopp, Mrs. Henry W., Jr.....2237 Poplar St.
 Bopp, Mrs. James.....236 S. 21st St.
 Boyd, Mrs. H. Clark.....651 Oak Dr.
 Brown, Mrs. Robert R.....2544 N. Ninth

C-D

CaJacob, Mrs. Melville E.....1000 S. Sixth St.
 Caldwell, Mrs. M. V.....R. R. 7, Box 449
 Combs, Mrs. Stuart R.....2620 N. 10th St.
 Conforti, Mrs. Victor P.....2540 N. 10th St.
 Conklin, Mrs. James O.....127 Adams St.
 Conway, Mrs. Thomas J.....1014 So. 22nd Street
 Crockett, Mrs. Wayne A.....152 Monterey Ave.
 Davis, Mrs. M. J.....1444 S. 6th St.
 Denny, Mrs. E. Rankin.....2718 Wilson Dr.
 Drummy, Mrs. W. W. Jr.....231 Fruitridge
 Dyer, Mrs. G. Wallace.....2710 Wilson Dr.

E-F

Freed, Mrs. John E., Sr.....2408 N. 10th St.
 Freed, Mrs. John E., Jr.....2425 North 8th St.
 Fuqua, Mrs. H. B.....2303 N. Ninth St.

G

Gerrish, Mrs. Don A.....R. R. No. 7
 Gilbert, Mrs. Ivan.....2641 Crawford St.
 Gillote, Mrs. J. P.....R. R. 7
 Goodman, Mrs. Hubert T.....220 Gardendale Rd.
 Gossom, Mrs. Donn R.....1904 Ohio Blvd.

H

Haslem, Mrs. Ezra R.....30 Circle Drive
 Hogan, Mrs. Thomas W.....332 So. 31st Street
 Humphrey, Mrs. Paul E.....2631 N. Ninth St.

J-K

Johnson, Mrs. Paul D. Jr.....3101 Poplar St.
 Kabel, Mrs. Robert N.....2201 Ohio Blvd.
 Krieble, Mrs. W. W.....10 Bogart Dr.
 Kunkler, Mrs. Arnold W.....147 Monterey Ave.

L

Lancet, Mrs. Robert O.....20 Nitchie Dr.
 Lee, Mrs. James C.....12 Thirty-second St.
 Loewenstein, Mrs. Werner L.....1909 Ohio Blvd.
 Luckett, Mrs. C. L.....R. R. 2
 Lyons, Mrs. L. Mason.....123 S. 21st St.

M

McAleese, Mrs. George.....1438 S. 6th St.
 McBride, Mrs. Noel S.....67 Allendale Place
 McCrea, Mrs. Fred R.....2517 N. Eighth St.
 McEwen, Mrs. James W.....107 Wren Dr.
 McIntosh, Mrs. Wilbert.....R. R. No. 4
 McLaughlin, Mrs. Gordon.....R. R. 3, Box 128
 Mahoney, Mrs. Charles L.....R. R. 3, Box 172
 Malone, Mrs. L. A.....2511 N. 9th St.
 Mankin, Mrs. William.....130 S. 20th St.
 Mason, Mrs. Lester M.....66 Allendale Place
 Mattox, Mrs. Don A.....240 Hamilton Dr.
 Mattox, Mrs. Ernest.....240 Hamilton Dr.
 Miklozek, Mrs. J. E.....2204 Ohio Blvd.
 Miller, Mrs. D. B.....920 So. 6th St.
 Mitchell, Mrs. Albert M.....333 S. 22nd St.
 Musselman, Mrs. Glenn.....7222 Wabash Avenue

N-O-P

Nay, Mrs. Ernest O.....29 S. 20th St.
 Neudorff, Mrs. L. G.....213 Barton Avenue
 Oliphant, Mrs. Robert W.....8 31st St. Ct.
 Pearce, Mrs. Roy V.....269 S. 26th Street Dr.

R

Reed, Mrs. Robert C.....1933 S. Center St.
 Reynolds, Mrs. R. J.....72 Allendale Place
 Richart, Mrs. James V.....336 Hamilton Dr.
 Rogers, Mrs. Shirrell R.....1101 S. 6th St.
 Rubin, Mrs. M. M.....2401 Ohio Blvd.

S

Scherb, Mrs. Burton E.....211 Gardendale Rd.
 Schott, Mrs. Edward J.....653 Oak St.
 Schumaker, Mrs. Robert A.....R. R. 4
 Shaffer, Mrs. James S.....2200 Third Ave.
 Showalter, Mrs. John R., Jr.....2511 N. Eighth St.
 Siebenmorgen, Mrs. Louis.....1200 S. Eighth St.
 Siebenmorgen, Mrs. Paul.....2515 N. Seventh St.
 Silverman, Mrs. Norman M.....1142 S. Center St.
 Stoeltzing, Mrs. J. L.....1919 N. Seventh St.
 Strecker, Mrs. William L.....88 Allendale Pl.
 Sullivan, Mrs. John M.....2242 College Ave.

T-V

Taylor, Mrs. Donald J.....9 Chickadee Dr.
 Topping, Mrs. Malachi C.....3505 Ohio Blvd.
 Veach, Mrs. Wm. L.....10 Monroe Blvd.
 Voges, Mrs. Ed. C.....327 Hamilton Dr.

W-Z

Weber, Mrs. Joseph.....2121 N. 11th St.
 Weinbaum, Mrs. Jack G.....2705 Oak St.
 White, Mrs. James V.....1227 S. Sixth St.
 Wiedemann, Mrs. Frank E.....1530 S. Sixth St.
 Wilson, Mrs. F. L.....1124 S. Center
 Zwerner, Mrs. Paul F.....2510 N. Eighth St.

WABASH COUNTY

Walker, Mrs. James L.....P. O. Box 8, LaFontaine

Wabash

Dannacher, Mrs. William.....518 North Wabash
 Elward, Mrs. Carl.....550 Hamlin St.
 Goldstone, Mrs. Harvey.....East Hill

Hanneken, Mrs. Vincent.....86 Comstock St.
 LaSalle, Mrs. Richard.....126 Parkway
 LaSalle, Mrs. R. M.....442 N. Wabash St.
 LaSalle, Mrs. Robert M. Jr.....R. F. D. #4
 Mills, Mrs. John F.....24 East Main
 Pearson, Mrs. William E., R. F. D., Pleasant Valley
 Rauh, Mrs. Robert.....620 Bond Street
 Whisler, Mrs. Frederick M.....111 East Hill

WASHINGTON-ORANGE COUNTIES

Salem

Apple, Mrs. Eddie R.....501 W. Market
 Coleman, Mrs. Henry G.....R. R. 4
 Episcopopol, Mrs. A. R.....Salem
 Fultz, Mrs. Roy L.....307 W. Market
 Huckleberry, Mrs. Irvin E.....502 W. Mulberry
 Paynter, Mrs. Lawrence W.....202 E. Walnut

Paoli

Manship, Mrs. Stanley.....Main St.
 McCalla, Mrs. Charles X.....R. R. 1
 Spears, Mrs. John K.....N. Gospel St.

Tower, Mrs. Kermit T.....Campbellsburg
 Kestic, Mrs. Nicholas.....French Lick
 Sugarman, Mrs. Benjamin E.....French Lick
 Hodgins, Mrs. Phillip T.....Orleans

WAYNE-UNION COUNTIES

Kenyon, Mrs. Emil.....303 Mulberry, Cambridge City
 Barton, Mrs. William M., North Morton, Centerville
 Stepleton, Mrs. John D.....R. R. 2, Centerville
 Shepard, Mrs. Fred F.....College Corner
 Hutchison, Mrs. Don R.....Fountain City
 Clarkson, Mrs. C. G.....Liberty
 Lewis, Mrs. J. Frank.....Liberty
 McWilliams, Mrs. William B.....Liberty

Richmond

Adney, Mrs. Frank.....214 S. E. Parkway
 Ake, Mrs. Loren.....220 S. 18th St.
 Brown, Mrs. Richard J.....231 S. 15th St.
 Buche, Mrs. Frederick P.....2408 S. "E" St.
 Coble, Mrs. Frank H.....Liberty Pike
 Cook, Mrs. Norman R.....30 S. 21st St.
 Cox, Mrs. Leon T.....10 Clifton Rd.
 Daggy, Mrs. B. T.....2500 S. "A" St.
 Daggy, Mrs. James R.....2422 S. "D" St.
 Dingle, Mrs. Paul E.....206 S. 32nd St.
 Dreyer, Mrs. Ralph W.....410 S. W. "F" St.
 Ebbinghouse, Mrs. Tom.....Spring Grove Heights
 Griffin, Mrs. V. C.....201 S. 23rd St.
 Guthrie, Mrs. James R.....3112 S. E. Parkway
 Harmon, Mrs. Carl J.....Keystone Apt. 6
 Herring, Mrs. George N., Richmond State Hospital
 Hill, Mrs. Harold D.....123 S. 23rd St.
 Johnson, Mrs. George M.....115 S. 23rd St.
 Kime, Mrs. Charles E.....501 S. 19th St.
 Klepfer, Mrs. Jefferson F., Richmond State Hosp.
 Ling, Mrs. John F.....6 Parkway Lane
 Logan, Mrs. James Z.....15 Parkway Lane
 Loomis, Mrs. Charles H.....Garwood Rd.
 Mader, Mrs. John H.....1528 Chester Blvd.
 Meredith, Mrs. Elwood J.....200 S. 20th St.
 Miller, Mrs. Harold L.....603 S. 23rd St.
 Millis, Mrs. Arthur B.....4 Sunset Dr.
 Park, Mrs. Byron J.....303 S. 23rd St.
 Passino, Mrs. James.....115 S. 16th St.
 Pentecost, Mrs. Paul S.....1300 Chester Blvd.
 Plasterer, Mrs. Edward D.....212 S. 16th St.
 Ramsdell, Mrs. Glenn A.....Henley Rd. So.
 Ross, Mrs. Harry P.....220 S. 19th St.
 Sage, Mrs. Charles V.....416 S. 18th St.

Sherer, Mrs. Kenneth E.....232 S. 15th St.
 Shields, Mrs. Tom S.....2203 S. "E" St.
 Stilwell, Mrs. William R.....2607 S. C. Place
 Taylor, Mrs. William R.....27 S. 14th St.
 Wanninger, Mrs. Horace.....315 S. 15th St.
 Warrick, Mrs. Francis B.....2106 South "B" St.
 Weitemier, Mrs. R. A.....25 S. 25th St.
 Wertemberger, Mrs. Morris...206 Henley Rd. So.
 Whallon, Mrs. Arthur J.....29 S. 10th St.
 Wiland, Mrs. Olin K.....2603 S. C. Place
 Wynegar, Mrs. David E...Richmond State Hospital

WELLS COUNTY

Bluffton

Bishop, Mrs. Robert E.....1200 Sycamore Lane
 Boonstra, Mrs. Charles E.....1110 Highland Pk. Circle
 Bradley, Mrs. Louis.....504 W. South St.
 Caylor, Mrs. Charles H.....1220 Sycamore Lane
 Caylor, Mrs. Harold D.....411 W. Market St.
 Cook, Mrs. Robert G.....1225 Summitt Ave.
 Dorrance, Mrs. Thomas O.....302 Northwood Dr.
 Eisaman, Mrs. Jack L.....1011 Riverview Dr.
 Jackson, Mrs. Charles E.....1012 Riverview Dr.
 Kephart, Mrs. Bruce.....910 Riverview Dr.
 Meier, Mrs. Donald W.....1205 Summitt Dr.
 Milroy, Mrs. Robert.....1010 Summit Ave.
 Pietz, Mrs. David.....120 West South St.
 Smith, Mrs. H. Brooks.....333 S. Wayne
 Symon, Mrs. William E.....620 S. Main St.
 Talbert, Mrs. Pierre C.....508 W. Cherry
 Yoder, Mrs. Richard P.....931 South Wayne

WHITE COUNTY

Derhammer, Mrs. George L.....Brookston
 Netherton, Mrs. C. R.....Chalmers
 Houser, Mrs. Wayne.....Monon
 McClure, Mrs. Stanley E.....Monon

Monticello

Beck, Mrs. David C.....R. #3
 Benson, Mrs. J. Thomas.....1112 O'Conner
 Carney, Mrs. John.....R. R. #2
 Dickerson, Mrs. W. Martin.....218 E. Market St.
 Fullerton, Mrs. Robert L.....Beach Drive
 Hibner, Mrs. Nolan A.....214 S. Illinois
 Morris, Mrs. Warren V.....R. R. #3

Mayfield, Mrs. C. H.....Reynolds
 Baynes, Mrs. Frank.....Wolcott

WHITLEY COUNTY

Hershey, Mrs. Ernest A., Jr.....Churubusco
 Minich, Mrs. Linus J.....Churubusco

Columbia City

Hamilton, Mrs. Thomas G.....416 W. Market St.
 Heritier, Mrs. G. Jules.....410 E. Van Buren St.
 Horswell, Mrs. Richard.....Jackson St.
 Langohr, Mrs. John L.....321 N. Main St.
 Lehmberg, Mrs. Otto F.....West Park Dr.
 Luckey, Mrs. James.....R. R. #4
 Niccum, Mrs. Warren L.....Brennan Addn.
 Nolt, Mrs. E. V.....Westwood Park
 Reid, Mrs. Donald B.....Westpark Dr.
 Roth, Mrs. James R.....Route 4
 Thompson, Mrs. Frank.....R. R. 4
 Vogel, Mrs. John L.....Jefferson St. Ext.

Waite, Mrs. Jerome H.....R. R. 5
 Wilson, Mrs. John S.....313 S. Chauncey St.

Mishler, Mrs. Joseph B.....Pierceton
 Stalter, Mrs. Gaylord.....North Webster
 Huffman, Mrs. Park...701 State St., South Whitley

MEMBERS-AT-LARGE

Alford, Mrs. James A.....Hamilton, Steuben
 Amy, Mrs. William E.....120 S. Capitol, Corydon, Harrison-Crawford
 Artz, Mrs. Richard W.....606 Darling, Angola, Steuben
 Balsbaugh, Mrs. George.....1514 N. Wayne St., North Manchester, Wabash
 Beardsley, Mrs. Frank A.....751 E. South St., Frankfort, Clinton
 Benz, Mrs. Jesse C.....Box 115, Marengo, Harrison-Crawford
 Blessinger, Mrs. Louis H.....738 N. Capitol Ave., Corydon, Harrison-Crawford
 Bogardus, Mrs. Carl R.....Kyana Farm, Austin, Scott
 Burkhardt, Mrs. Boyd.....328 N. West St., Tipton, Tipton
 Cameron, Mrs. Don F.....313 E. Maumee, Angola, Steuben
 Caryle, Mrs. Ivan E.....Michigantown, Clinton
 Carneal, Mrs. T. E.....305 S. Market St., Winamac, Pulaski
 Carter, Mrs. Jean V.....215 Green St., Tipton, Tipton
 Cook, Mrs. Charles E.....112 N. Market St., North Manchester, Wabash
 Compton, Mrs. Harry M.,.....221 N. Independence, Tipton, Tipton
 Covell, Mrs. Harry M.....909 Midway Dr., Auburn, DeKalb
 Crain, Mrs. James W.....Williamsport, Fountain-Warren
 Dannacher, Mrs. William D.....518 N. Wabash, Wabash, Wabash
 Dukes, Mrs. David J.....439 E. Chestnut, Corydon, Harrison-Crawford
 Dukes, Mrs. F. M.....Dugger, Sullivan
 Ericson, Mrs. Harold L.....Box #1356, Windfall, Tipton
 Eshelman, Mrs. Henry R.....Box #156, Monterey, Pulaski
 Eskew, Mrs. Kenneth W.....336 French, Sullivan, Sullivan
 Garvin, Mrs. Donald V.....508 Locust Dr., Brazil, Clay
 Hall, Mrs. Donald L.....Petersburg, Pike
 Hathaway, Mrs. Clayton B.....410 N. Broadway, Butler, DeKalb
 Hoffman, Mrs. Max N.....709 Park Ave, Covington, Fountain-Warren
 Hollenburg, Mrs. Edward L.....813 N. Hathaway, Winamac, Pulaski
 Humphrey, Mrs. E. M.....1005 Orchard, Covington, Fountain-Warren
 Jinnings, Mrs. Loren.....807 S. Lee, Garrett, DeKalb
 Kantzer, Mrs. Floyd B.....608 E. Keyser St., Garrett, DeKalb
 Kincaid, Mrs. Raymond...R. R. #1, Tipton, Tipton
 Kurtz, Mrs. W. A.....R. R. #1, Tipton, Tipton
 Lett, Mrs. E. Briscoe.....502 W. 1st St., Loogootee, Daviess-Martin
 Lynch, Mrs. Otis R.....Marengo, Harrison-Crawford
 Mason, Mrs. Donald G.....401 E. Maumee, Angola, Steuben
 Maurer, Mrs. Frank...6 E. Park St., Brazil, Clay

Maurer, Mrs. Robert . . . 304 E. McLain, Brazil, Clay
 McClain, Mrs. Marvin L.
 1115 E. McClain, Scottsburg, Scott
 McKittrich, Mrs. Jack
 No. 1 Green Acres, Washington, Daviess-Martin
 McNaughton, Mrs. L. M.
 6 Brentwood Dr., Washington, Daviess-Martin
 Mehne, Mrs. Richard G.
 1½ E. National, Brazil, Clay
 Mount, Mrs. Mathias S.
 340 W. Mechanic, Worthington, Greene
 Norton, Mrs. Horace
 511 E. Hefron St., Washington, Daviess-Martin
 Omstead, Mrs. Milton
 1105 6th St., Petersburg, Pike
 Pearson, Mrs. William E.
 290 N. Wabash, Wabash, Wabash
 Person, Mrs. Theodore C.
 600 N. Main, Veedersburg, Fountain-Warren
 Petrich, Mrs. P. R.
 409 E. Washington, Attica, Fountain-Warren
 Rang, Mrs. Arthur A.
 211 N. E. 9th St., Washington, Daviess-Martin
 Raymundo, Mrs. Viviano
 114 David Dr., Attica, Fountain-Warren
 Rohrer, Mrs. James R. Elnora, Daviess-Martin
 Rotman, Mrs. Sam
 603 S. Washington, Jasonville, Greene
 Schrepferman, Mrs. Wayne
 Box #222, Hamilton, Steuben
 Scott, Mrs. Irvin H.
 30 W. Washington, Sullivan, Sullivan
 Seat, Mrs. Marshall H.
 310 Hefron, Washington, Daviess-Martin
 Smith, Mrs. Byron J. . . Kingman, Fountain-Warren
 Smith, Mrs. Lloyd H.
 R. R., North Manchester, Wabash
 Stephens, Mrs. Lowell R.
 600 E. Wayne St., Covington, Fountain-Warren
 Stoops, Mrs. Jean T.
 563 N. Miami, Wabash, Wabash
 Stouder, Mrs. Albert E. Kempton, Tipton
 Thompson, Mrs. William R. Winamac, Pulaski

Tranter, Mrs. W. F.
 4 E. Walnut St., Sharpsville, Tipton
 Turner, Mrs. Jack J.
 227 W. Main St., Bloomfield, Greene
 Wait, Mrs. Chester Box 817, Colfax, Clinton
 Webster, Mrs. Robert K.
 25 N. Beech St., Brazil, Clay
 Weirich, Mrs. Charles S.
 Box 126, R. R. #1, Butler, DeKalb
 Woner, Mrs. John R. R. #3, Linton, Greene
 Work, Mrs. B. A.
 451 Howard Terrace, Frankfort, Clinton

NOBLE-LaGRANGE

(Newly-Organized)

(Members are listed alphabetically without regard to town of residence.)

Benedict, Mrs. Charles D. R.R. #1, LaGrange
 Bowman, Mrs. Charles M. Albion
 Gutstein, Mrs. Richard R.
 120 Diamond, Kendallville
 Lehman, Mrs. Kenneth M. Topeka
 Luckey, Mrs. Robert C. Wolf Lake
 Miller, Mrs. Jerry A.
 107 South Mountain, LaGrange
 Munk, Mrs. C. E. . . . West Mitchell St., Kendallville
 Nash, Mrs. Justin R. 202 N. Orange, Albion
 Pulskamp, Mrs. B. H. Wolcottville
 Slough, Mrs. O. Thomas
 112 West Mitchell, Kendallville
 Sneary, Mrs. Kenneth D. Avilla
 Sneary, Mrs. Max E., 205 Baum Avilla
 Stone, Mrs. Robert C. 401 S. Main St., Ligonier
 Studebaker, Mrs. Lloyd R. LaGrange
 Stultz, Mrs. Quentin F. . . . 3 Hawthorn Dr., Ligonier
 Williams, Mrs. H. O.
 735 Mitchell St., Kendallville
 Williams, Mrs. John H.
 221 Van Buren, Shippshewana
 Yunker, Mrs. Philip Box 188, Howe

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Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 10th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.

ANOTHER YEAR OF SYMPOSIA . . .

RICHARDSON SPRINGS, CALIFORNIA

Sunday, June 11, 1961
Richardson's Mineral Springs

SPRINGFIELD, MASSACHUSETTS

Wednesday, June 14, 1961
The Schine Inn

CHEYENNE, WYOMING

Monday, July 24, 1961
The Plains Hotel

MCALISTER, OKLAHOMA

Saturday, July 29, 1961
The Aldridge Hotel

SEATTLE, WASHINGTON

Saturday, August 5, 1961
The Olympic Hotel

KANSAS CITY, KANSAS

Friday, September 15, 1961
Battenfeld Memorial Auditorium

TOLEDO, OHIO

Thursday, September 28, 1961
The Commodore Perry Hotel

WICHITA, KANSAS

Wednesday, October 4, 1961
The Broadview Hotel

TRAVERSE CITY, MICHIGAN

Friday, October 13, 1961
The Park Place Hotel

PEORIA, ILLINOIS

Thursday, October 26, 1961
The Hotel Pere Marquette

PROVIDENCE, RHODE ISLAND

Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA

Thursday, November 9, 1961
The Penn Harris Hotel

JACKSONVILLE, FLORIDA

Sunday, November 12, 1961
The Robert Meyer Hotel

ALLENTOWN, PENNSYLVANIA

Wednesday, November 15, 1961
The Americas Hotel



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Class A Narcotic Drugs

The following is a compilation of Class A Narcotic Drugs by Trade Name prepared by L. C. Heustis, Executive Secretary of the Indiana Pharmaceutical Association for publication. It is designed to aid physicians in determining the proper and legal methods of prescribing narcotics. A pharmacist is required by law to have in hand a properly completed prescription prior to the dispensing of any of the Class A narcotics. No verbal or phoned prescriptions are permitted in Class A.

Package	Class A Narcotics by Trade Name	Package	Class A Narcotics by Trade Name
Tab.	A.P.C. Demerol (Demerol 30 mg.)	Vial	Demerol 50 mg. per cc.
Supp.	B&O 15A (Opium $\frac{1}{2}$ gr., Belladonna $\frac{1}{4}$ gr.)	Vial	Demerol 100 mg. per cc.
Supp.	B&O 16A (Opium 1 gr., Belladonna $\frac{1}{4}$ gr.)	Vial	Demerol Scopolamine (Demerol 50 mg. per cc.)
	Chlor-Anodyne (Morphine Hcl. $2\frac{7}{8}$ gr. per oz.)	Tab.	Demerol APAP (Demerol 50 mg.)
	Cocaine Solutions	Tab.	Demerol Comp. (Demerol 25 mg.)
Solvets	Cocaine Hcl. $2\frac{1}{4}$ gr.	Tab.	Demerol Lotusate (Demerol 100 mg.)
Amp.	Codeine Phos. $\frac{1}{2}$ gr. per cc.	Tab.	Dicodid 5 mg.
H.T.	Codeine Phos. $\frac{1}{4}$ gr.	Amp.	Dilaudid Hcl. $1/32$ gr.—1 cc.
H.T.	Codeine Phos. $\frac{1}{2}$ gr.	Amp.	Dilaudid Hcl. $1/20$ gr.—1 cc.
H.T.	Codeine Phos. 1 gr.	Amp.	Dilaudid Hcl. $1/16$ gr.—1 cc.
D.T.	Codeine Sulf. 1 gr.	Rect. Supp.	Dilaudid Hcl. $1/20$ gr.
H.T.	Codeine Sulf. $\frac{1}{8}$ gr.	Syr.	Dilaudid (1 mg.—5 cc.)
H.T.	Codeine Sulf. $\frac{1}{4}$ gr.		Dilaudid Hcl. Solutions
H.T.	Codeine Sulf. $\frac{1}{2}$ gr.	H.T.	Dilaudid Hcl. $1/64$ gr.
H.T.	Codeine Sulf. 1 gr.	H.T.	Dilaudid Hcl. $1/32$ gr.
T.T.	Codeine Sulf. $\frac{1}{4}$ gr.	H.T.	Dilaudid Hcl. $1/20$ gr.
T.T.	Codeine Sulf. $\frac{1}{2}$ gr.	H.T.	Dilaudid Hcl. $1/16$ gr.
T.T.	Codeine Sulf. 1 gr.	Vial	Dilaudid Sulf. 2 mg. per cc.
	Codeine, if more than 8 grs. per fl. oz. or more than 1 gr. per dosage unit		Dionin Solutions
	Demerol Solutions	Amp.	Dolophine Hcl. 10 mg.—1 cc. (Methadone Hcl.)
Amp.	Demerol 25 mg.— $\frac{1}{2}$ cc.	20 cc. Amp.	Dolophine Hcl. 10 mg. per cc.
Amp.	Demerol 50 mg.—1 cc.	Syr.	Dolophine Hcl. (Methadone Hcl. 10 mg. per 30 cc.)
Amp.	Demerol 75 mg.— $1\frac{1}{2}$ cc.	Tab.	Dolophine Hcl. 5 mg.
Amp.	Demerol 100 mg.	Tab.	Dolophine Hcl. 7.5 mg.
Amp.	Demerol Atropine 2 cc. (Demerol 100 mg—2 cc.)	Tab.	Dolophine Hcl. 10 mg.
Amp.	Demerol Scopolamine 2 cc. (Demerol 100 mg—2 cc.)	Tab.	Donagesic #2 (Codeine Phos. $1\frac{1}{2}$ gr.)
Elix.	Demerol (Demerol 50 mg. per 5 cc.)		Dover's Po. N.F. (Po. Ipecac and Opium)
	Demerol Disp. Syr. 50 mg.—1 cc.	H.T.	H.M.C. #1 (Morphine HBr. $\frac{1}{4}$ gr.)
	Demerol Disp. Syr. 75 mg.—1 cc.	H.T.	H.M.C. #2 (Morphine HBr. $\frac{1}{8}$ gr.)
	Demerol Disp. Syr. 100 mg.—1 cc.		Hycodan Po.
Tab.	Demerol 50 mg.	10 cc. Vial	Hymorphan Hcl. 2 mg. per cc.
Tab.	Demerol 100 mg.		

Package	Class A Narcotics by Trade Name
10 cc. Vial	Hymorphan Hcl. 2 mg. per cc. Atropine Sulf. 0.25 mg. per cc.
Amp.	Leritine 1 cc., 25 mg. per cc.
Amp.	Leritine 2 cc., 25 mg. per cc.
Tab.	Leritine 25 mg.
30 cc. Vial	Leritine 25 mg. per cc.
Amp.	Levo-Dromoran 2 mg.—1 cc.
Tab.	Levo-Dromoran 2 mg.
10 cc. Vial	Levo-Dromoran 2 mg. per cc.
Tubex	Meperidine Hcl. 50 mg.—1 cc.
Tubex	Meperidine Hcl. 75 mg.—1 cc.
Tubex	Meperidine Hcl. 100 mg.—1 cc.
Tubex	Mepergan 25—50 mg. per 2 cc.
10 cc. Vial	Mepergan 25—25 mg.—1 cc.
Tubex	Mepergan 50—50 mg.—1 cc.
10 cc. Vial	Mepergan 50—50 mg.—1 cc.
100 Tab.	Mercodione
20 cc. Vial	Methadone Hcl. 1 mg. per cc.
30 cc. Vial	Methadone Hcl. 10 mg. per cc.
Syr.	Methajade Morphine Acetate
Elix.	Morphine Hcl. 1 gr. per fl. oz. Morphine Solutions
Amp.	Morphine Sulf. $\frac{1}{4}$ gr. per cc.
Amp.	Morphine Sulf. $\frac{1}{4}$ gr., Atropine Sulf. 1/150 gr. per cc.
H.T.	Morphine Sulf. $\frac{1}{8}$ gr.
H.T.	Morphine Sulf. $\frac{1}{6}$ gr.
H.T.	Morphine Sulf. $\frac{1}{4}$ gr.
H.T.	Morphine Sulf. $\frac{1}{2}$ gr.
H.T.	Morphine Sulf. 1 gr.

Package	Class A Narcotics by Trade Name
H.T.	Morphine Sulf. $\frac{1}{4}$ gr., Atropine Sulf. 1/150 gr.
T.T.	Morphine Sulf. $\frac{1}{4}$ gr.
Amp.	Nisentil Hcl. 40 mg.—1 cc.
Amp.	Nisentil Hcl. 60 mg.—1 cc.
Vial	Nisentil Hcl. 60 mg. per cc.
Tab.	Nodaline (Methadone Hcl. 2.5 mg.)
Amp.	Numorphan Hcl. 1 cc. (1.5 mg per cc.)
Amp.	Numorphan Hcl. 2 cc. (1.5 mg. per cc.)
10 cc. Vial	Numorphan Hcl. (1.5 mg. per cc.)
Supp.	Numorphan Hcl. 2 mg.
Supp.	Numorphan Hcl. 5 mg. Opium Po. Opium Po. Extract
Rect. Supp.	Opium 1 gr. Belladonna $\frac{1}{4}$ gr.
Tr.	Opium U.S.P. Deod. Pantopen All Papine
Amp.	Prinadol 2 mg. 1 cc.
10 cc. Vial	Prinadol 2 mg. per cc.
Amp.	Spasmalgin 1 cc. (Pantopon 1/6 gr. Papaverine Hcl. 1/3 gr. 1 cc.)
Tab.	Spasmalgin (Pantopon 1/6 gr. Papaverine Hcl. 1/3 gr.)
Cap.	Synalgos DC (Dihydrocodeine 16 mg.)

The 4 Narcotic Classes*

The Karsten narcotic law, which became effective January 1, has resulted in the division of all narcotic drugs as follows:

CLASS A—This is the old, original basic narcotic drug class, used to control products that have addiction liability. Preparations in this class are subject to the strictest controls all the way down the line. Examples would include Cocaine, Dolophine, Demerol, Morphine, Pantopon, etc. They cannot be dispensed without a written prescription, and, of course, cannot be refilled.

CLASS B—This group was established a few years ago when Congress authorized oral prescriptions for a limited group of narcotic drug-preparations. Included in this class are: Apomorphine, A. S. A. and Codeine Compounds, Copavin, Cotarnine, Dihydrocodeinone, Narcotine and Narceine. Dihydrocodeinone was transferred to this group from Class X and is no longer exempt.

CLASS X—This is the category of so-called exempts—narcotic preparations found by the federal narcotics bureau to have only a slight addition liability. Narcotic form order is not required.

CLASS M—This is the new control group, created under the Karsten law. Drugs in this class have no addiction liability, or less liability than those in Class X. Narcotic order not required. This class was created by transferring preparations into it from Class B: combinations of non-narcotic ingredients with narcotine, papaverine, narceine, or cotarnine. However, pure narcotine, papaverine, narceine, cotarnine, and their salts remain as Class B drugs, to be dispensed only on prescription.

Watch the new labels. ◀

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Deaths of Indiana Physicians in 1960

Compiled by James B. Maple, M.D., Necrologist

(M) Member I.S.M.A.; (S) Senior Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death
Jones, Hiram H.	74	Jan. 1	Salamonia	Carcinoma colon, carcinomatosis
Dill, Lawrence L.	75	Jan. 2	Logansport	Chronic myocarditis. Generalized arteriosclerosis
Walker, Frank C. (S)	79	Jan. 3	Indianapolis	Coronary embolism
Markel, Ivan J. (M)	73	Jan. 7	Elkhart	Myocardial infarction
Hutchinson, Barzella M.	73	Jan. 7	Mishawaka	Carcinoma of the lung
Ivey, Donnell R. (R)	81	Jan. 17	Monticello	Generalized arteriosclerosis
Luckey, Harold A. (M)	63	Jan. 19	Columbia City	Septicemia
Beetem, Luther F. (M)	58	Jan. 26	Madison	Died from injuries received from a fall at home
Laird, Leslie A. (M)	65	Jan. 30	Richmond	Coronary occlusion
Williams, Theodore L.	57	Feb. 1	Bloomington	Burns, shock, bronchopneumonia
Combs, Charles N. (S)	80	Feb. 7	Terre Haute	Cerebral arteriosclerosis
Allison, Rutherford H.	32	Feb. 9	Michigan City	Myocardial infarction, coronary artery disease
Miller, J. Don (S)	78	Feb. 10	Indianapolis	Coronary occlusion, myocardial infarction, acute G. I. hemorrhage
Walker, William G. (M)	29	Feb. 10	Gary	Overdose of nembutal
Savery, Charles E. (R)	70	Feb. 13	South Bend	Myocardial infarction, arteriosclerotic heart disease
Wyland, Byron J. (S)	76	Feb. 17	Mishawaka	Myocardial infarction
Yencer, Martin W. (S) (R)	88	Feb. 22	Richmond	Uremia, generalized arteriosclerosis
Buttz, Julia Rose (S)	87	Feb. 28	Indianapolis	Arteriosclerotic heart disease
Ball, Robert S.	60	Mar. 2	Lebanon	Acute coronary insufficiency, cardiovascular arteriosclerosis
Laughlin, John	92	Mar. 2	Bedford	Inanition
Bassett, Clancy (S)	80	Mar. 17	Thorntown	Coronary thrombosis
VanKirk, John A. (R)	69	Mar. 19	Frankfort	Cerebrovascular accident, generalized arteriosclerosis
Lloyd, Claude A. (M)	84	Mar. 19	Washington	Carcinoma of sigmoid colon, carcinomatosis
Hudson, Eugene H.	74	Mar. 21	Anderson	Carcinomatosis
Bottomoff, Charles M.	99	Mar. 26	Charlestown	Uremia
Rothring, Howard E. (M)	40	Mar. 27	Crothersville	Myocardial infarction, arteriosclerotic heart disease
McGauvran, Theodore (M)	58	Mar. 29	East Chicago	Coronary thrombosis
Eby, Ida L. (S)	78	Mar. 29	Warren	Chronic brain syndrome with senility
Bender, Cecil K. (M)	53	Apr. 7	Goshen	Acute coronary thrombosis
Schaefer, C. Richard (S)	90	Apr. 13	Indianapolis	Rectal hemorrhage, probable carcinoma
Hinchman, Clarence P. (M)	68	Apr. 22	Geneva	Hepatitis
Craven, Howard T.	39	Apr. 27	Indianapolis	Accidental electrocution
Murphy, Harold O. (M)	38	Apr. 27	Warsaw	Bronchopneumonia
Ulmer, David R. (S)	89	Apr. 30	Terre Haute	Cerebral thrombosis
Carr, Silas J.	81	May 3	Indianapolis	Cerebral embolism
Take, John F.	96	May 12	French Lick	Cerebral thrombosis
Gratz, Raymond J.	38	May 16	Indianapolis	Cancer right lung
Wisener, Guthrie H. (S)	74	May 18	Richmond	Bacteremia and meningitis
Dugan, William M. (M)	55	May 19	Indianapolis	Massive cerebral hemorrhage
Dudding, Joseph E. (M)	53	May 20	Hope	Dissecting aneurysm
Ottinger, Ross C. (S)	77	May 24	Indianapolis	Fracture right femur, pneumonia
Swihart, Leonard F. (M)	61	May 28	Elkhart	Coronary occlusion
Sandorf, Marvin H. (M)	52	May 31	Indianapolis	Peritonitis, ruptured gastric ulcer
Whallon, Arthur J. (S)	73	June 1	Richmond	Pulmonary emphysema
Vail, George A. (M)	45	June 3	Lawrenceburg	Drowning, boating accident

Name	Age	Date of Death	Address	Cause of Death
Elliott, Lloyd A. (S)	75	June 16	Elkhart	Cerebral thrombosis
Knepple, LaMar R. (S)	88	June 24	Kokomo	Hypostatic pneumonia, generalized arterio-sclerosis
Brenner, Andrew M. (M)	49	June 28	Winchester	Congestive heart failure
Williams, Aubrey H. (M)	51	July 5	Fort Wayne	Massive hemoptysis, carcinoma esophagus
Nisenbaum, Harold (M)	47	July 14	Evansville	Acute coronary occlusion
Gilkison, John S. (S)	83	July 18	Shoals	Coronary occlusion, generalized arterio-sclerosis
Rawles, Lyman T. (S) (R)	82	July 18	Fort Wayne	Pulmonary infarction
Chevigny, Julius J. (M)	57	July 19	Gary	Acute coronary occlusion, myocardial infarction
Schulze, Hans A. (M)	55	July 19	Indianapolis	Coronary occlusion, arteriosclerotic heart disease
Dancer, Charles R. (S)	87	July 26	Fort Wayne	Arteriosclerotic heart disease
Dalton, John E. (M)	59	Aug. 5	Indianapolis	Coronary occlusion, hypertension, arterio-sclerotic heart disease
Fine, Nathaniel J. (M)	44	Aug. 5	Indianapolis	Acute myocardial infarction
Borders, Theodore R. (M)	58	Aug. 14	Fort Wayne	Coronary thrombosis, myocardial infarction
Michaels, J. F. (S) (R)	84	Aug. 25	Edinburg	Arteriosclerotic heart disease
VanArsdall, Clarence R. (M)	61	Aug. 26	Terre Haute	Epidermoid carcinoma of esophagus
Hull, Arthur W. (M)	68	Aug. 27	Elkhart	Cerebral hemorrhage
Culmer, Walter N. (S) (R)	84	Aug. 30	Indianapolis	Uremia, generalized arteriosclerosis
DeFoe, Walter A.	83	Aug. 30	Richmond	Cerebral thrombosis
Condit, David H.	65	Sept. 2	South Bend	Arteriosclerotic heart disease, carcinoma of prostate
Selsam, Etta	78	Sept. 8	Terre Haute	Cerebral thrombosis, generalized arterio-sclerosis
Wood, Elmer U. (S)	89	Sept. 16	Columbus	Cerebral thrombosis, sclerosis cerebral vessels
Glosson, Jack R. (M)	41	Sept. 22	Clay City	Auto wreck
Pierce, Harold J. (S)	78	Oct. 2	Terre Haute	Acute coronary thrombosis
Larkin, Bernard J. (S)	73	Oct. 5	Indianapolis	Ruptured abdominal aneurysm
Leff, Abe H. (M)	40	Oct. 5	Indianapolis	Coronary occlusion
McCaskey, Carl H. (S)	83	Oct. 8	Indianapolis	Cerebral thrombosis
Franklin, Wesley B.	79	Oct. 23	East Chicago	Bronchopneumonia
Thornton, Walter E. (S)	82	Oct. 27	Fort Wayne	Arteriosclerotic heart disease
Davis, Merle (M)	42	Oct. 28	Terre Haute	Gunshot wound of the head
Logan, Austin (R)	85	Nov. 5	Petersburg	Pneumonia
Riley, Francis H. (S) (R)	86	Nov. 7	Jamestown	Prostatic carcinoma
Warfel, Frederick C. (S)	80	Nov. 11	Indianapolis	Bronchopneumonia, generalized arterio-sclerosis
Brickley, Harry D. (S)	74	Nov. 16	Bluffton	Acute coronary occlusion
Larrabee, William H. (S)	90	Nov. 16	New Palestine	Aplastic anemia, lymphosarcoma
Gannon, George W. (S)	81	Nov. 17	Gary	Cerebral hemorrhage, general arterio-sclerosis
Stellner, Howard A. (M)	50	Nov. 19	Fort Wayne	Coronary occlusion, posterior myocardial infarction
Owens, Richard R. (M)	50	Nov. 22	Muncie	Congestive heart failure, rheumatic heart disease
Gwinn, Benjamin C.	42	Dec. 1	Eaton	Cerebral hemorrhage, hypertension
Kattman, Bertha (R)	78	Dec. 2	Brazil	C.V.R.D.
Brooke, Hugh Cleveland	72	Dec. 6	Terre Haute	Coronary occlusion
Shonk, Harold W. (M)	41	Dec. 11	Noblesville	Coronary thrombosis, myocardial infarction
Patton, Martin T. (M)	70	Dec. 11	Indianapolis	Coronary occlusion, arteriosclerotic heart disease
Callahan, Richard H. (M)	47	Dec. 16	East Chicago	Acute coronary thrombosis
Coble, Ralph R. (S)	81	Dec. 22	Indianapolis	Coronary occlusion, arteriosclerotic heart disease
Canaday, Clifford E. (S)	84	Dec. 26	New Castle	Hypostatic pneumonia
Fruth, Virgil J. (M)	70	Dec. 26	Connersville	Arteriosclerotic heart disease

Presidents of ISMA Since Its Organization

Medical Convention	Elected	Served	Medical Convention	Elected	Served
*Livingston Dunlap, Indianapolis----	1849	1849	*Walker Schell, Terre Haute-----	1899	1900
Medical Society			*George W. McCaskey, Ft. Wayne----	1900	1901
*William T. S. Cornett, Versailles----	1849	1850	*Alembert W. Brayton, Indianapolis--	1901	1902
*Ashahel Clapp, New Albany-----	1850	1851	*John B. Berteling, South Bend-----	1902	1903
*George W. Mears, Indianapolis-----	1851	1852	*Jonas Stewart, Anderson-----	1903	1904
*Jeremiah H. Brower, Lawrenceburg	1852	1853	*George T. MacCoy, Columbus-----	1904	1905
*Elizur H. Deming, Lafayette-----	1853	1854	*George H. Grant, Richmond-----	1905	1906
*Madison J. Bray, Evansville-----	1854	1855	*George J. Cook, Indianapolis-----	1906	1907
*William Lomax, Marion-----	1855	1856	*David C. Peyton, Jeffersonville-----	1907	1908
*Daniel Meeker, LaPorte-----	1856	1857	*George D. Kahlo, French Lick-----	1908	1909
*Talbot Bullard, Indianapolis-----	1857	1858	*Thomas C. Kennedy, Shelbyville-----	1909	1910
*Nathan Johnson, Cambridge City---	1858	1859	*Frederick C. Heath, Indianapolis----	1910	1911
*David Hutchinson, Mooresville-----	1859	1860	*William F. Howat, Hammond-----	1911	1912
*Benjamin S. Woodworth, Ft. Wayne	1860	1861	*A. C. Kimberlin, Indianapolis-----	1912	1913
*Theophilus Parvin, Indianapolis----	1861	1862	*John P. Salb, Jasper-----	1913	1914
*James F. Hibberd, Richmond-----	1862	1863	*Frank B. Wynn, Indianapolis-----	1914	1915
*John Sloan, New Albany-----	1863	----	*George F. Keiper, Lafayette-----	1915	1916
*John Moffet (acting), Rushville----	1863	1864	*John H. Oliver, Indianapolis-----	1916	1917
*Samuel L. Linton, Columbus-----	1864	----	*Joseph Rilus Eastman, Indianapolis	1917	1918
*Wilson Lockhart (acting), Danville--	1864	1865	*William H. Stemm, North Vernon----	1918	1919
*Myron H. Harding, Lawrenceburg---	1865	1866	*Charles H. McCully, Logansport-----	1919	1920
*Vierling Kersey, Richmond-----	1866	1867	*David Ross, Indianapolis-----	1920	1921
*John S. Bobbs, Indianapolis-----	1867	1868	*William R. Davidson, Evansville----	1921	1922
*Nathaniel Field, Jeffersonville-----	1868	1869	*Charles H. Good, Huntington-----	1922	1923
*George Sutton, Aurora-----	1869	1870	*Samuel E. Earp, Indianapolis-----	1923	1924
*Robert N. Todd, Indianapolis-----	1870	1871	*Eldridge M. Shanklin, Hammond-----	1924	1925
*Henry P. Ayres, Ft. Wayne-----	1871	1872	*Charles N. Combs, Terre Haute-----	1925	1926
*Joel Pennington, Milton-----	1872	1873	*Frank W. Cregor, Indianapolis-----	1926	1927
*Isaac Casselberry, Evansville-----	1873	----	George R. Daniels, Marion-----	1926	1928
*Wilson Hobbs (acting), Knightstown	1873	1874	*Charles E. Gillespie, Seymour-----	1927	1929
*Richard E. Houghton, Richmond----	1874	1875	*Angus C. McDonald, Warsaw-----	1928	1930
*John H. Helm, Peru-----	1875	1876	*Alois B. Graham, Indianapolis-----	1929	1931
*Samuel S. Boyd, Dublin-----	1876	1877	Franklin S. Crockett, Lafayette-----	1930	1932
*Luther D. Waterman, Indianapolis---	1877	1878	*Joseph H. Weinstein, Terre Haute--	1931	1933
*Louis Humphreys, South Bend-----	1878	----	*Everett E. Padgett, Indianapolis----	1932	1934
*Benj. Newland (acting), Bedford			*Walter J. Leach, New Albany-----	1933	1935
(v.p.) -----	1878	1879	Roscoe L. Sensenich, South Bend---	1934	1936
*Jacob R. Weist, Richmond-----	1879	1880	*Edmund D. Clark, Indianapolis-----	1935	1937
*Thomas B. Harvey, Indianapolis----	1880	1881	Herman M. Baker, Evansville-----	1936	1938
*Marshall Sexton, Rushville-----	1881	1882	*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
*William H. Bell, Logansport-----	1882	1883	Karl R. Ruddell, Indianapolis-----	1938	1940
*Samuel E. Mumford, Princeton-----	1883	1884	*Albert M. Mitchell, Terre Haute----	1939	1941
*James H. Woodburn, Indianapolis----	1884	1885	Maynard A. Austin, Anderson-----	1940	1942
*James S. Gregg, Ft. Wayne-----	1885	1886	*Carl H. McCaskey, Indianapolis----	1941	1943
*General W. H. Kemper, Muncie-----	1886	1887	*Jacob T. Oliphant, Farmersburg----	1942	1944
*Samuel H. Charlton, Seymour-----	1887	1888	*Neslen K. Forster, Hammond-----	1943	1945
*William H. Wishard, Indianapolis---	1888	1889	*Jesse E. Ferrell, Fortville-----	1944	1946
*James D. Gatch, Lawrenceburg-----	1889	1890	*Floyd T. Romberger, Lafayette-----	1945	1947
*Gonsolvo C. Smythe, Greencastle----	1890	1891	*Cleon A. Nafe, Indianapolis-----	1946	1948
*Edwin Walker, Evansville-----	1891	1892	Augustus P. Hauss, New Albany-----	1947	1949
*George F. Beasley, Lafayette-----	1892	1893	*C. S. Black, Warren-----	1948	1950
*Charles A. Daugherty, South Bend---	1893	1894	Alfred Ellison, South Bend-----	1949	1951
*Elijah S. Elder, Indianapolis-----	1894	----	*J. William Wright, Indianapolis----	1950	1952
*Charles S. Bond (acting), Richmond	1894	1895	Paul D. Crimm, Evansville-----	1951	1953
*Miles F. Porter, Ft. Wayne-----	1895	1896	Wm. Harry Howard, Hammond-----	1952	1954
*James H. Ford, Wabash-----	1896	1897	Walter L. Portteus, Franklin-----	1953	1955
*William N. Wishard, Indianapolis---	1897	1898	Walter U. Kennedy, New Castle-----	1954	1956
*John C. Sexton, Rushville-----	1898	1899	Elton R. Clarke, Kokomo-----	1955	1957
			M. C. Topping, Terre Haute-----	1956	1958
			Kenneth L. Olson, South Bend-----	1957	1959
			Earl W. Mericle, Indianapolis-----	1958	1960
			Guy A. Owsley, Hartford City-----	1959	1961

* Deceased.

Constitution and By-Laws of the Indiana State Medical Association

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSE OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members*.—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members*.—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members*.—Senior members shall be physicians of the State of Indiana who have attained the age of seventy years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members. Eligi-

bility to senior status shall begin the year after the member reaches the age of seventy.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members*.—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members*.—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer with power to vote. Besides its duties mentioned in the Bylaws, it shall constitute the Board of Trustees of this organization,

having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. No Councilor shall be eligible to serve longer than two consecutive three-year terms, effective with the beginning of his next election following the adoption of this amendment.

All of these officers shall serve until their successors are elected and installed. Provided, that if

any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the executive secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors

at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor.

In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the executive secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call.

Sec. 10.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

BYLAWS

CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these Bylaws unless otherwise indicated shall mean both active and senior members of component county medical societies who hold either the Degree of Doctor of Medicine or Bachelor of Medicine.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Committee on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Medical.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. General Practice.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Radiology.
- i. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county.

The number of Delegates to which each Component Society is entitled shall be based upon the

number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before December first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5.—Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The president, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Council shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of councilors shall begin with the first meeting of the Council following the final session of the House of Delegates at the Annual Session.

Sec. 2.—Each Councilor shall be organizer, peacemaker, and censor for his district. He shall

visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when

organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall at its meeting following the close of the House of Delegates elect two members of the Association, at large, or of the Council, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Council they shall not have the power of vote in the Council.

CHAPTER VIII.—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1.—The work of the Association, the performance of which is not provided for elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Council or of the House of Delegates, or by Special Committees created by the Executive Committee, the Council, or the House of Delegates, shall be performed by the following standing committees and commissions:

- The Executive Committee
- The Grievance Committee
- The Student Loan Committee
- The Medical-Legal Review Committee
- The Commission on Convention Arrangements
- The Commission on Constitution and Bylaws
- The Commission on Legislation
- The Commission on Public Information
- The Commission on Governmental Medical Services

The Commission on Public Health

The Commission on Voluntary Health Agencies

The Commission on Medical Economics and Insurance

The Commission on Inter-Professional Relations

The Commission on Medical Education and Licensure

The Commission on Special Activities

The Commission on the Aged and Aging

The difference between committees and commissions is shown in the provision of these Bylaws pertaining to their work and composition.

Sec. 2.—Unless otherwise provided in these Bylaws, the committees shall be appointed by the President with the chairman of each committee designated by him, and the number constituting each committee shall be as indicated in the section of these Bylaws pertaining to each particular committee.

Sec. 3.—Each commission will consist of fifteen members appointed by the President, with at least one member from each councilor district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

Sec. 4.—The President shall have the power, with the approval of the Council, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Sec. 5.—Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or commission more than two consecutive terms, but this shall not prevent him serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Sec. 6.—Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. Then this joint meeting will divide into meetings of the separate commissions,

at which time the commissions and committees will organize by the election of chairman, vice-chairman and secretary, unless otherwise provided for in these Bylaws. In these meetings the commissions may provide for such subcommittees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Sec. 7.—Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Sec. 8.—Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family; and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

Sec. 9.—The President and Executive Secretary shall be *ex officio* members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER IX.—THE EXECUTIVE COMMITTEE

Section 1.—The Executive Committee, constituted as provided in Section 12 of Chapter VII of these Bylaws, shall hold its first meeting immediately following the meeting of the Council held at the close of the last meeting of the House of Delegates in the annual convention, and shall organize by electing its chairman. Its secretary shall be the Executive Secretary of the Association. It shall meet with the Executive Secretary on the call of the Chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall have all jurisdiction with respect to medical defense activities of the Association and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to

THE JOURNAL, during the intervals between the meetings of the Council, and shall report its actions to the Council.

Sec. 2.—It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

CHAPTER X.—THE GRIEVANCE COMMITTEE

Section 1.—The Grievance Committee shall be composed of nine physicians, three of whom may be past presidents of the Association, and all of whom shall be appointed by the President. Not more than two physicians shall be appointed from any one councilor district. No member shall hold any elective office in the State Association during tenure on this committee. Of the nine physicians first appointed, three shall serve for a period of one year; three for two years; and three for three years. Thereafter, three shall be appointed each year for a three-year term to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee, other than by expiration of term, shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, a vice-chairman and a secretary.

Sec. 2.—This provision regarding the constitution of the Grievance Committee shall be construed to mean that the present committee of that name is continued in that position with the terms of its members expiring and new members to be appointed on the basis of this provision being operative and effective as of the dates of their respective original appointments; and it is not to be construed as having the effect of creating a new committee, all of whose members are to be appointed upon this amendment being adopted and becoming effective.

Sec. 3.—In addition to the above provided organization and membership of the committee, the President of the Association shall appoint an accredited psychiatrist as a consultant for the committee, whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any councilor district of the Association, irrespective of the membership of the committee including another member or members from the same councilor district. He shall have the same rights and privileges as other members of the

committee except that he shall not have the right to vote.

Sec. 4.—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Council of the State Association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing its procedure and official actions.

CHAPTER XI.—THE COMMISSION ON CONVENTION ARRANGEMENTS

Section 1.—The Commission on Convention Arrangements, with the advice and assistance of the Executive Secretary, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official programs, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 2.—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the annual convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the annual convention.

Sec. 3.—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

CHAPTER XII.—THE STUDENT LOAN COMMITTEE

Section 1.—The Student Loan Committee shall be constituted as follows:

- (a) The President of Indiana State Medical Association
- (b) One Councilor of the Association to be appointed by the President

- (c) One general practitioner to be appointed by the President
- (d) One specialist to be appointed by the President
- (e) The Treasurer of Indiana State Medical Association
- (f) The Dean of Indiana University School of Medicine
- (g) One of the attorneys of Indiana State Medical Association to be appointed by the President

Sec. 2.—This committee shall have authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. The committee shall organize itself at its first meeting following the annual convention of the Association, by the election of a chairman and a secretary. The committee shall adopt its own rules and regulations, subject to the approval of the Council. The secretary shall have the duty and responsibility of keeping minutes of all transactions of the committee, and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

CHAPTER XIII.—THE MEDICAL-LEGAL REVIEW COMMITTEE

Section 1.—The Medical-Legal Review Committee shall consist of three members whose duty it shall be to meet in joint session and work with a similar committee to be appointed by the President of the State Bar Association. This committee of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association.

CHAPTER XIV.—THE COMMISSION ON CONSTITUTION AND BYLAWS

Section 1.—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

CHAPTER XV.—THE COMMISSION ON LEGISLATION

Section 1.—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and of the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

CHAPTER XVI.—THE COMMISSION ON PUBLIC INFORMATION

Section 1.—The Commission on Public Information shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the Commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

CHAPTER XVII.—THE COMMISSION ON GOVERNMENTAL MEDICAL SERVICES

Section 1.—The Commission on Governmental Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the Government, plans and programs of the Government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

CHAPTER XVIII.—THE COMMISSION ON PUBLIC HEALTH

Section 1.—The Commission on Public Health shall assemble and study information regarding industrial medical practice, rural health, preventive medicine, placement of physicians, traffic safety, conservation of hearing and vision; and shall bring such information, and the possibility of progress and advancement in such fields, to the attention of the medical profession, with suggestions for improvements as the commission finds such possibilities.

CHAPTER XIX.—THE COMMISSION ON VOLUNTARY HEALTH AGENCIES

Section 1.—The Commission on Voluntary Health Agencies shall maintain liaison between all voluntary health agencies and the Association; shall study and counsel in regard to planning all educational and other activities of such agencies; and shall keep the Association fully informed at all times regarding present and contemplated programs of these agencies.

CHAPTER XX.—THE COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

Section 1.—The Commission on Medical Economics and Insurance shall study and improve forms used in medical and hospital insurance; shall continuously be interested in all types of plans for prepayment of medical and hospital expense, and for provision for medical and hospital service through all types of group activity; shall maintain liaison with labor with respect to labor's problems involving medical and hospital care, and Workmen's Compensation problems; and shall seek improved solutions of professional liability or malpractice problems, tax problems in relation to medical practice, and problems involving physician retirement plans.

CHAPTER XXI.—THE COMMISSION ON INTER-PROFESSIONAL RELATIONS

Section 1.—The Commission on Inter-Professional Relations shall study to find all the best methods of maintaining on the highest and most satisfactory levels physicians' professional relations with hospitals, nurses, dentists, pharmacists, pharmaceutical manufacturers, veterinarians, nursing homes, and all other professional groups with which the practice of medicine comes into contact.

CHAPTER XXII.—THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE

Section 1.—The Commission on Medical Education and Licensure shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

CHAPTER XXIII.—THE COMMISSION ON SPECIAL ACTIVITIES

Section 1.—The Commission on Special Activities shall organize and promote support for the American Medical Education Fund, assistance to physicians, blood banks, and all miscellaneous activities not falling within the area of responsibilities of other commissions or committees.

CHAPTER XXIV.—THE COMMISSION ON THE AGED AND AGING

Section 1.—The duties of this Commission shall be to study, investigate, and make recommendations to the Association in the areas falling within the question of the aged and aging, including medical care programs, medical care insurance, rehabilitation, and preventive medicine.

CHAPTER XXV.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the President from among those who are members of the House of Delegates. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

- (1) Sections and Section Work
- (2) Rules and Order of Business
- (3) Medical Education and Hospitals
- (4) Legislation
- (5) Public Relations
- (6) Hygiene and Public Health
- (7) Amendments to the Constitution and By-laws
- (8) Reports of Officers
- (9) Credentials
- (10) Insurance
- (11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the

President, be made (a) to as many reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee as are necessary to cover all subjects the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XXVI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine or a degree of Bachelor of Medicine, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall

be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of

his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members.

The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay \$10.00 as dues for the remainder of that year. Interns and residents shall pay \$10.00 a year annual dues during their term of service in the hospital.

In the event the county society remits a member's dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing why such recommendation should be granted. The councilor in turn shall present the recommendation to the Council, which shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution or Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Secretary of the Indiana State Medical Association not later than May 1 of each

calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Secretary.

CHAPTER XXVII.—COUNCILOR DISTRICT MEDICAL SOCIETIES

Section 1.—A Councilor District Medical Society, hereinafter called the District Society, shall be a society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District, provided such members of County Medical Societies have paid their membership dues in the District Society.

Sec. 2.—The State shall be divided into thirteen (1) Councilor Districts with the boundary lines and numbers of each District to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton and White Counties.

Tenth District—Newton, Jasper, Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Sec. 3.—Each District Society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one District Society shall exist within any one Councilor District. The authorized District Society in each Councilor District shall receive a charter from the State Association, and the Secretary of the District Society shall have custody of the charter.

Sec. 4.—Each District Society shall organize by electing a President, a Secretary, and a Treasurer and a Councilor and Alternate Councilor as the

current Councilor term and Alternate Councilor term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of Secretary and Treasurer may be held by the same physician. The Councilor shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Sec. 5.—The dues of the District Society, in an amount fixed by the District Society to meet the District Society needs, shall be collected by the Secretaries of the component County Societies and delivered to the Treasurer of the District Society. The Secretary of each District Society shall report to the office of the State Association the names and addresses of the members of his District Society, together with a copy of the minutes of each meeting of the District Society.

Sec. 6.—Each District Society shall meet at least once each year at a time and place to be fixed by the District Society. On or before January 1st of each year each District Society shall notify the headquarters of the State Association of the time and place of the annual District meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Council, the Councilor shall fix the time and place of the District meeting, and notice of such meeting shall be sent to the members of the County Medical Societies in such District.

Sec. 7.—Whenever a District Society is to elect a Councilor and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such District Society not later than the first of March of the year in which the election is to occur.

Sec. 8.—The District Society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the District of the meeting at least thirty (30) days prior to the date thereof.

CHAPTER XXVIII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and Bylaws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XXIX.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This Committee shall have full authority governing all matters pertaining to this Chapter. In order to secure to any physician sued or against whom claim is made a fair and full presentation of his defense, the Committee shall have power to enter into an agreement with such physician to furnish to him funds with which to employ and pay one attorney of his choice and such other expenses as the Committee may approve as necessary to a fair and full presentation of his defense. Provided, always, that the attorney selected by the physician must be of good reputation and standing in his profession and the terms of employment, including the fees to be paid, must be approved by the Committee in each case in advance of such agreement. Provided, further, that the Executive Committee shall set a limit to the amount which may be so expended in connection with any one claim or case.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XXX.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying

directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XXXI.—INVESTMENT OF SURPLUS FUNDS

Section 1.—The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the in-

vestment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

CHAPTER XXXII.—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

How Social Security Medical Reports Are Used

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SINCE JANUARY, 1955, when the first disability provision in the social security law became effective, the Social Security Administration has received about one and one-half million disability claims. Four hundred and fifty thousand claims were received during the past year.

In practically all cases, the worker's attending physician furnishes a medical report. This report, together with reports from other physicians, hospitals, or clinics, provides the primary basis for determining whether the worker meets the social security requirements of disability.

The social security law defines disability as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration." In order to meet this definition and other requirements of the law the following conditions must be met:

1. The claimant's condition must be medically determinable—that is, it must be a condition that can be confirmed by medical examinations and tests.
2. The condition must be so severe that it prevents the person not only from carrying on his last or usual occupation but also from performing any substantial gainful activity.
3. The condition must have persisted for at least six months, despite therapy, and must be expected to continue indefinitely or to result in death.

4. The condition must not be remediable through treatment that is safe and reasonable according to usually accepted standards of medical practice.

5. The claimant must have a record of work under social security. In this connection, his work record must include a definite number of calendar quarters of social security coverage. This requirement is designed to limit disability benefits to regular workers who have been forced to stop work because of disability.

Medical Report Form for Doctor's Convenience

Disabled people apply for benefits at their nearest social security district office. That office gives a person information about his rights, helps him to fill out his application and advises him about the proofs and documents that he may need to support his application. The disabled claimant has the responsibility to furnish, at his own expense, sufficient medical evidence for a reviewing physician to establish the presence of an injury or disease. This medical evidence should be in sufficient detail for the evaluation of the severity, duration and remediability of the condition. The social security office gives the claimant an explanatory letter and one or more copies of a medical report form which he is instructed to take or mail to his attending physician or any other physician, clinic, hospital, institution, or agency in which he has been treated for his condition. These reports are returned directly to the requesting office in the accompanying preaddressed envelopes.

The medical report form is furnished for the convenience of the physician, clinic, or hospital—doctors or institutions should not feel bound by its format or brevity. What is needed is a full clinical picture of the patient's condition. This

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requires a history and physical and supporting laboratory findings in sufficient detail to permit a reviewing physician to make an independent diagnosis and evaluate therapeutic possibilities as well as the patient's capacity for work. The information should be as complete as that which is usually obtained from the first clinic studies done for diagnostic and therapeutic purposes. If possible, a careful description of any limitations on the patient's ability to walk, sit, stand, bend, think, hear, see and manipulate should be included. If the physician wishes, he may furnish the requested information in a narrative statement, using his own stationery instead of the form.

A well-prepared medical report can speed the determination of eligibility for disability benefits to a disabled patient. It will also avoid the need for more correspondence for additional clinical or laboratory data.

Determinations of Disability Made by States

Determination as to whether a claimant meets the definition of disability contained in the social security law is made, under federal-state agreement, by an agency of the state in which the claimant resides. In most states, this is the vocational rehabilitation agency.

Evaluation of disability is made in the state agency by a review team. One member of the team is a doctor of medicine, the other is a non-medical member trained in disability evaluation. Determination of disability is a joint decision. The reviewing physician is primarily responsible for evaluating the severity, duration, and remediability of the "medically determinable impairment." The nonmedical member of the team evaluates the applicant's ability to perform substantial gainful work in the light of his education, training, work history, and demonstrated vocational skills.

The state evaluating team must decide whether the applicant is unable to engage in any substantial gainful activity due to a medically determinable condition which is expected to continue without significant improvement for a long and indefinite time. In carrying out this function, it is often essential for the state agency to arrange for, and purchase at government expense independent medical examinations and tests to supplement information already on file from the claimant's own medical sources. This can be done only after the applicant has presented enough evidence that the reviewing physician believes

it reasonably likely that a severe impairment exists. Consultative examinations cannot be used to relieve the applicant of his responsibility to submit medical evidence.

Consultative examinations may be purchased for one or more of the following reasons:

1. To obtain highly technical evidence believed to be necessary for sound evaluation by the reviewing physician and which the attending physician is unable to provide. Such evidence might be an actual measure of the applicant's capacity to consume oxygen at a specified rate.

2. There are medical reports in the file from two or more sources and the review team physician is unable to reconcile the separate pieces of evidence.

3. The attending physician's report describes severity (functional), remediability, or duration characteristics which in the opinion of the reviewing physician are inconsistent with the supporting history and physical and laboratory findings.

4. The attending physician's diagnostic, therapeutic, and prognostic conclusion, in the opinion of the reviewing physician, is not supported by history and physical and laboratory data, and attempts to obtain such additional information from the attending physician have not been successful.

5. The applicant gives notice of contesting his case at higher judicatory levels and the reviewing physician believes the case would be better supported or the attending physician's evidence strengthened with a second independent examination.

6. When the person is currently on the disability rolls and it appears that his disability may have ceased.

The state agency medical consultant or reviewing physician decides when a consultative examination is necessary, who is to make it and the type and scope of the examination. When a physician is asked to perform a consultative examination he is advised that the government will pay his fee. State practice governs the amount of the fee. The examination may range from a simple laboratory test to a complete medical examination including work evaluation and complete diagnostic services.

State determinations are reviewed by the Bureau of Old-Age and Survivors Insurance for consistency and conformity to national policies.

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SOCIAL SECURITY

Continued

The bureau, however, is not empowered to reverse a state decision which is unfavorable to the applicant. Such a decision can only be reversed through the appeals process.

Claimant's Right to Appeal

Any claimant who does not believe that the decision on his claim is correct may ask that his case be reconsidered. In this event his case (including any additional evidence that may not have been presented earlier) will be carefully re-examined by both the state agency and the bureau. If the results of this reconsideration leave the claimant still dissatisfied, he may request a hearing before a hearing examiner of the Social Security Administration.

Of the one and one-half million disabled workers who have filed claims since January, 1955, only about 40,000, or less than three percent, have requested hearings before a hearing examiner. The hearing examiner makes a complete and independent review of the case, much the same as a judge in a court of law. At the hearing, the claimant may present the case himself or he may have a representative to help him. He and his representative have the right to examine all evidence made part of the record, including medical reports.

Where hearing examiners conducting hearings have found that additional medical information was necessary, attending or consulting physicians are asked to provide the required information in writing, rather than orally or in person. The hearing examiners request such information through the state agency. The state agency's request may go to the attending physician or a consulting physician. All requests for additional evidence are made to the attending physician. There are some exceptions which were discussed previously. In addition, qualified medical sources are available to the hearing examiner for securing advice and counsel.

A claimant who is dissatisfied with the hearing examiner's decision may take his case to the federal court. In cases before the federal court, no new testimony is taken from doctors or from others. The court merely reviews the record and decides whether the decision is supported by substantial evidence.

Doctor's Responsibility

Although his opinion is highly regarded and carefully considered, the attending examining

doctor does not have to determine that his patient suffers a "disability." The law places this responsibility on the state and federal administrative agencies.

Misunderstandings occasionally arise because doctors sometimes append to their report conclusions such as: "My patient is permanently and totally disabled." As the foregoing discussion shows, the concept of disability includes requirements other than a disease and its characteristics. Therefore, conclusions based solely on clinical facts are sometimes inconsistent with those that have taken into account requirements in addition to clinical data. The doctor's report of the patient's chief complaint or of a physical finding can seldom be debated. A laboratory finding speaks for itself. Likewise, the doctor's observations that the patient can walk, stand, sit, bend, see, and the degree of efficiency with which he can perform these functions, are legitimate and important reasons for medical concern. This type of evidence provides the reviewing physician with a sound basis for determining whether the applicant has an impairment which, in the language of the law, makes him unable "to engage in substantial gainful activity."

By limiting himself to these kinds of clinical facts and observations, the examining physician avoids the need of committing himself with regard to either the "totality" or the "permanence" of his patient's condition. It is advisable for the physician to inform his patient that his report is limited to clinical facts and observations. The patient, then, cannot attribute an unfavorable decision to his doctor's report. Hence, any dissatisfaction which the applicant may have with the final determination will not be directed toward the doctor.

Vocational Rehabilitation. — All disability claimants are considered for possible services by the state vocational rehabilitation agency. The goal is to restore as many disabled persons as possible to the labor force. The doctor may want to keep this in mind when completing the medical report since he may have knowledge which would assist the rehabilitation counselor in planning and providing services for the patient.

Confidentiality of Medical Reports.—Medical reports furnished by attending doctors in connection with their patients' claims for disability benefits are of paramount importance in the successful administration of the social security disa-

bility program. As an integral part of the claim file, each report is safeguarded by the same legal restrictions which govern the confidential nature of all social security records. Only in certain authorized circumstances can medical reports be divulged. For example, medical information provided by the doctor may be made available to

another government agency for use in developing a plan for the worker's rehabilitation. However, at a hearing before a hearing examiner, when the claimant is contesting the decision, the disabled person or his representative has the right to examine all the evidence on which the decision was based, including medical reports.

**DON'T DELAY IN
MAKING RESERVATIONS . . .**

112th Annual Convention

**INDIANA STATE
MEDICAL ASSOCIATION**

October 24-26

**Murat Temple
Indianapolis**

These dates are somewhat in conflict with meeting dates of the Indiana State Teachers' Association. All members are urged to make hotel reservations early in order to avoid a shortage of hotel space.

The Dynamics of Blue Shield

and their relation to the future of private medical care

(One of a series of articles prepared by Blue Cross-Blue Shield)

Extracts from a speech by Ira C. Layton, M.D., Vice President of Surgical-Medical Care, Kansas City, Mo., made at the Indiana Blue Shield 1961 Seminar for the Blue Shield Advisory Council.

What of the relationship between Blue Shield and the medical profession which created it? Certainly in the beginning this relationship was good. Blue Shield provided income for services where income otherwise might not have been available. Blue Shield has been and continues to be the most effective defense against the inroads of agencies who wish to insert themselves into the practice of medicine.

Over the years, many factors have tended to discourage this excellent relationship. Much less often now does the physician have to worry about his patient's ability to pay a reasonable fee. Reception rooms are filled with patients who are well acquainted with wonder drugs, the ravages of cancer and the dangers of heart disease. Relative affluence has led many physicians to believe that Blue Shield is no longer an economic necessity and interest in the program has waned. The unforeseen success of Blue Shield has made it difficult for administrative staffs and governing boards to keep the physician informed of their problems and decisions have been made without soliciting the opinion of the profession in general. A gradual parting of the ways has occurred between busy doctors with little time for Blue Shield and a busy Blue Shield personnel with little time for professional relations.

Physicians began to look upon Blue Shield

as "just another insurance company" and to wonder why we, as physicians, were engaged in insurance practices. As physicians' fees increased to make up for mounting overhead and cost of living, too often Blue Shield fee schedules remained static. The Blue Shield subscriber who felt he had purchased a high-grade "doctors' plan" found in his mail a supplemental bill from his physician and was understandably irritated. Criticism was directed toward the physician and the physician, in turn, reflected it upon the inadequate payment of his Blue Shield plan. Subscriber and physician alike sometimes found that commercial returns were far more adequate for certain procedures.

The progress of medicine with increased specialization and differentiation of fees between the general practitioner and specialist, particularly those engaged in the non-surgical specialties, has in recent years produced an extremely difficult situation. A new generation of physicians unfamiliar with the background of Blue Shield and unversed in Blue Shield philosophies, has been highly critical of the programs. They look on Blue Shield as another interfering agency in their relationship with their patient. Blue Shield was created to represent the profession in economic affairs with the public. For numerous reasons, some of which I have mentioned, we have not kept faith with that particular trust.

Complacency and lack of interest leave the profession reluctant to permit Blue Shield to alter the status quo. This must be changed. Also at the meeting in Chicago, much emphasis

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—April, 1961

Disease	Apr. 1961	Mar. 1961	Feb. 1961	Apr. 1960	Apr. 1959
Animal Bites	527	536	334	633	641
Chickenpox	613	1138	897	548	636
Conjunctivitis	105	136	150	130	151
Diphtheria	1	0	0	0	1
Dysentery, Unspecified	25	23	94	25	17
Impetigo	79	92	88	84	67
Infectious Hepatitis	285	366	234	77	36
Infectious Mononucleosis	29	39	14	20	17
Influenza	437	823	495	781	2992
Measles (Rubeola-Rubella)	1022	1065	835	2028	998
Meningitis, Meningococcal	5	2	2	5	6
Meningitis, Other	9	10	2	12	11
Mumps	1001	1101	469	441	467
Pertussis	3	16	9	38	76
Pneumonia	173	229	237	159	331
Poliomyelitis	1	1	0	1	1
Streptococcal Infections	691	1156	874	1098	1032
Tinea Capitis	22	12	27	39	35

BLUE SHIELD

Continued

was placed on the need for improved relations between Blue Shield and the Medical Profession from the House of Delegates of the American Medical Association to the most isolated of practicing physicians. This can only be accomplished through extensive effort on the part of Blue Shield at the local, regional and national levels.

At this conference, the local plan delegates approved without dissenting vote a program designed by the National Professional Relations Committee and intended to accomplish Blue Shield's professional relations needs. This advisory council will accomplish much to serve the needs in Indiana.

These are our major current problems. With the cooperation of local plans and individual physicians, they will be successfully resolved. ◀



"I think we'd better reduce the amount of iron in those tablets you've been taking. I don't like that clanking sound when you walk!"



Medical Assistants' Convention Includes Varied Program, Installation of Officers

Newly-elected officers of the Indiana State Association of Medical Assistants, installed at the group's fifth annual state convention in South Bend, April 22 and 23, are Mrs. Evelyn Montgomery, employed by Dr. W. R. Tindall, Shelbyville, president; Mrs. Irene Wells, employed by Dr. Julian D. Present, Evansville, president-elect; Mrs. Carolyn Appleby, employed by the State Hospital, Richmond, recording secretary; and Mrs. Alice Craig, employed by Dr. K. W. Kees, Muncie, treasurer.

Also Mrs. Thelma Firsich, employed by Dr. Roger Whitcomb, Shelbyville, corresponding secretary; and Miss Sheila LaGarde, Warsaw; Mesdames Lee Keys, Seymour; Lillian Holderman, Elkhart; Esther Moore, Lafayette; Bernice Gutknecht, Columbus; Marge Nafrady, South Bend, and Roberta Banister, Indianapolis, directors.

The programs included a tour of Lobund Laboratories and the Notre Dame campus; luncheon sponsored by Blue Shield, with Dr. Walter J. Portteus, Franklin, speaking; workshops led by Mr. Jack Owen, American Hos-

pital Association; Mr. Oliver Field and Mr. Leo Brown, AMA; and John MacCauley, of Notre Dame Foundation.

Banquet speaker was Rev. Leo Ward, of Notre Dame. Also at the banquet, honorary memberships were presented to Dr. Guy Owsley, ISMA president, and Mr. L. E. Converse, of Blue Shield.

It was reported that the 1961 membership of the organization is 390 women, representing 13 chapters in Indiana.

Ob-Gyn Applications Due August 1

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part 1, and requests for re-examination in Part 2 are now being accepted. Deadline date for receipt of applications is Aug. 1, 1961.

Candidates are requested to write to the office of the secretary for a current Bulletin if they have not done so in order that they might be well informed as to the present requirements.

Arthritis, Rheumatism Foundation Offers Investigatorship Awards

The Arthritis and Rheumatism Foundation is offering predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1962. Deadline for applications is Oct. 31, 1961.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

The program provides for three awards:

(1) *Predocctoral fellowships* are limited to students who hold a bachelor's degree. Each applicant studying for an advanced degree must be acceptable to the individual under whom the work will be done. These fellowships are tenable for one year, with prospect of renewal. Stipends range from \$2,000 to \$3,000 per year, depending upon the family responsibilities of the fellow.

(2) *Postdoctoral fellowships* are limited to applicants with the degree of Doctor of Medicine, Doctor of Philosophy—or their equivalent. These fellowships are tenable for one year, with prospect of renewal. Stipends range from \$5,000 to \$7,000 per year, depending upon the family responsibilities of the fellow.

(3) *Senior investigator awards* are made to candidates holding or eligible for a "faculty rank" such as instructor or assistant professor (or equivalent) and who are sponsored by their institution. Stipends are from \$7,000 to \$10,000 per year and are tenable for five years.

A sum of \$500 will be paid to cover the laboratory expenses of each postdoctoral fellow. An equal sum will be paid to either cover the tuition expenses or laboratory expenses of each predoctoral fellow. In the case of senior investigators, instead of the \$500, an additional 10% of the stipend will go to the institution to be applied to annuity programs, laboratory expenses, travel, etc.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

HAMMOND PHYSICIAN ELECTED NATIONAL BLUE SHIELD HEAD

Dr. W. H. Howard of Hammond, past president of ISMA, and current president of Indiana Blue Shield, is serving as president of the National Association of Blue Shield Plans. As he took office in April, Dr. Howard stressed the necessity for the Blue Shield plans to be adaptable to changing need and to pioneer new forms of coverage. At the same meeting the national association endorsed the Kerr-Mills Law method of providing



medical care for the aged.

Also at the April business meeting, R. S. Saylor, executive vice-president of Indiana Blue Shield, was elected a member of the Board of Directors of the national association.

Mr. Saylor was re-elected treasurer of Medical Indemnity of America, Inc., the national underwriting agency for all Blue Shield Plans, and also appointed to serve as a member of the joint operating committee of Medical Indemnity of America, Inc., and Health Service, Inc.

Fourth of Teaching Film Series Available to Professional Audiences

A new teaching film on external cardiac massage has been released by Smith, Kline & French Laboratories. This is the fourth of a series of films for professional audiences. It is a 21 minute, color and sound production and may be obtained on a free-loan basis by contacting the local SK&F representative. The other three films also available are titled: "Resuscitation of the Newborn," "Human Gastric Function" and "Recognition and Management of Respiratory Acidosis." SK&F teaching films are produced under professional direction and contain no product references of any kind.

Dr. Emmett B. Lamb, Indianapolis, chairman of the ISMA Commission on Public Health, was elected secretary of the Industrial Medical Association at an annual meeting in Los Angeles.

NEWS NOTES

Continued

Hospital Educators ISMA Guests At Program; Interview Students

Directors of hospital educational programs were guests of the ISMA, Wednesday, April 19, for a two-part program in the Union Building at the I. U. Medical Center.

Dr. Harry E. Klepinger, Lafayette, vice-chairman of the ISMA's Commission on Medical Education and Licensure, was in charge of the meeting.

At the morning session hospital representatives heard Dr. John J. Mahoney, associate dean of the I. U. School of Medicine, present the student viewpoint of hospital educational programs; Dr. Jack Hall, medical education director at Methodist Hospital (Indianapolis), discussed such programs in a community hospital; Robert Hollowell, ISMA attorney, outlined legal responsibilities; and Dr. Kenneth Kohlstaedt of the Commission on Medical Education outlined a statewide survey of hospital educational programs.

In the afternoon hospital representatives interviewed sophomore and junior medical students in regard to intern and extern programs in Indiana.

Two Hoosier Physicians to Teach At Postgrad Course in Jerusalem

Dr. Walter J. Aagesen of Anderson and Dr. Carl B. Sputh, Jr., of Indianapolis will join 23 other American specialists in nasal surgery to serve as instructors in the 2nd International Postgraduate Course to be presented in Jerusalem, Israel, August 6 to 17. The course is to be under the auspices of the Hebrew University-Hadassah Medical School of Jerusalem in cooperation with the American Rhinologic Society.

Surgeons Elect Dr. Scott

Dr. Frank Scott, South Bend, was elected president of the Indiana Chapter of the American College of Surgeons, at the organization's two-day session in Indianapolis April 14 and 15.

Other new officers are Drs. Weston A. Heinrich, Evansville, vice-president; J. S. Battersby, Indianapolis, secretary-treasurer; and Richard P. Good, Kokomo, president-elect.

THREE HOOSIERS NAMED FELLOWS AT OB-GYN COLLEGE MEETING

Three Indiana doctors were inducted as Fellows of the American College of Obstetricians and Gynecologists at its recent annual meeting in Bal Harbour, Fla.

Drs. Joseph F. Thompson, Indianapolis; Donald T. Bartlett, Vincennes and Henry Schroeder, Jr., Washington, were so honored at the organization's 10th Anniversary Meeting.

Dr. Nicholson J. Eastman, who recently retired as the head of the Department of Obstetrics of Johns Hopkins University, was inducted as President. Dr. Sprague Gardiner of Indianapolis participated in a panel discussion on anesthesia in obstetrics.

New Food Additives Reference Prepared by Chemists' Association

"Food Additives: What They are—How They Are Used" is a reference handbook prepared by the Manufacturing Chemists' Association.

As its name implies, a major portion of the handbook describes how and why the achievements of scientific research are applied by the food industry to the benefit of the consumer. Food additives are defined and their development explained. All types of additives are discussed, including such important and widely used substances as nutrient supplements, leavenings, mold inhibitors, emulsifiers, and flavors and spices.

Another section of the reference book outlines the steps involved in establishing the safety of food additives, Federal legislation relating to food additives, and the protection of food in general is discussed, including such recent laws as the Food Additives and Color Additive Amendments.

Physicians may obtain single copies of the booklet without charge by writing on institution or organization letterhead to the Association at 1825 Connecticut Ave., N. W., Washington 9, D. C.

Well-Known Urologist Dies

Word has been received of the death of Dr. Elmer Hess, world-famous urologist and past president of the AMA, at Erie, Pa. He has served on the scientific program for many Hoosier medical meetings in the past few years.

Hill-Burton Indiana Status Listed

According to the Department of Health, Education and Welfare, Hill-Burton Grants for Indiana as of Jan. 31, 1961, included 68 projects completed and in operation. Total cost for these was \$72,862,202, including a \$23,828,304 federal share and supplying 3,166 additional beds.

Twenty-nine projects, costing \$35,008,108 including a \$9,077,325 federal share and supplying 1,233 additional beds were under construction.

GP's Hold Two May Road Shows

Two recent Indiana Academy of General Practice road shows presented during May included one in Terre Haute, with Dr. Jack M. Hall, of Methodist Hospital Graduate Medical Center, Indianapolis, giving the program, and a meeting in Gary, with Drs. Eugene F. Senseny and John A. Googins presiding.

Dr. Lester Bibler, Indianapolis, spoke on medical economics and the relative value study at the Ninth Councilor District conference of the Illinois State Medical Association in March.

I.U. Professor Speaks to Tacoma Surgical Group

Dr. Harris B. Shumacker, Jr., Indianapolis, gave the banquet address at the annual meeting of the Tacoma Surgical Club, May 6 in Tacoma, Washington. His subject was "Lessons from a Review of the Historical Developments in Cardiovascular Surgery." The I. U. Surgery professor also read a paper on arterial obstruction during a scientific session.

Special About Family Doctor To Be Telecast June 27

"Dr. B," an hour-long television special depicting the real-life story of medical practice as seen through the eyes of a family doctor, will be broadcast on WFBM-TV, Channel 6, Indianapolis (NBC), Tuesday, June 27, 9-10 p.m. (EST).

The nationwide telecast will coincide with the annual meeting of the American Medical Association in New York City.



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FUTURE MEETINGS, SEMINARS, COURSES

Rocky Mountain Cancer Conference Set For July in Denver

The 15th Annual Rocky Mountain Cancer Conference, to be held at Denver's Brown Palace West, July 12 and 13, will feature panel discussions on "Detect Cancer in Time!—Procedures, Problems and Solution," and "Neoplasms of the Female Genital Tract."

Presidents of both the American Cancer Society and the American Medical Association will participate in the two-day program. Application has been made for A.A.G.P. accreditation.

Speakers on the Scientific program will include Drs. Ulrich R. Bryner, Salt Lake City; Vincent P. Collins, Houston; William Dock, Brooklyn; Manuel E. Lichtenstein, Chicago; John R. McDonald, Detroit; and John A. Wall, Houston.

Morning sessions on both days of the program will be devoted to panel discussions, followed by round table luncheons with speakers. Individual papers will be delivered in the afternoon sessions.

The Rocky Mountain Cancer Conference, held annually in Denver, is co-sponsored by the Colorado Division of the American Cancer Society and the Colorado State Medical Society.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 835 Republic Bldg., Denver 2, Colo.

Estes Park, Colorado, Chosen For Postgraduate Ophthalmology Course

The University of Colorado School of Medicine announces a postgraduate course in external ophthalmology to be held at the Stanley Hotel, Estes Park, Colorado, July 10 to 13, inc. Lectures and discussion periods will take place in the mornings under the guidance of University of Colorado faculty members and guest speakers.

Afternoons are open for trips in Estes Park, and entertainment features are scheduled for

each evening. Information may be obtained by writing the school at 4200 E. Ninth Ave., Denver 20.

1962 Meetings Scheduled By College of Surgeons

Meetings of the American College of Surgeons, scheduled for 1962, have been announced by the Secretary as follows:

The 48th Annual Clinical Congress, Oct. 15-19, 1962, will be held in Atlantic City, N. J.

A four-day section meeting for surgeons and graduate nurses will take place Jan. 29-Feb. 1 in Los Angeles, at the Statler-Hilton and Biltmore Hotels.

Detroit, Mich., will be the site of a three-day sectional meeting, March 5-7, at the Cadillac Hotel.

Another three-day session is planned for Memphis, Tenn., March 26-28, at Hotel Peabody.

April 16-18 are the dates set for a meeting at the Sheraton-Park Hotel, Washington, D. C.

Further information on these sessions may be obtained from the Secretary, ACS, 40 E. Erie St., Chicago 11.

Otolaryngology Course to Stress Current Advances and Trends

The University of Illinois College of Medicine Department of Otolaryngology will offer an intensive postgraduate basic and clinical program Sept. 23-30 for practicing otolaryngologists. The entire course is designed to bring into study a wide variety of current advances in management, therapy and philosophies.

The program is under the direction of Dr. Emanuel M. Skolnik; Drs. Maurice F. Snitman and Frederic J. Pollock are in charge of the review of basic morphologic features.

Interested physicians should write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12.

Deaths

Medicine Loses Enthusiastic, Loyal Colleague In Passing of Dr. Cleon A. Nafe

American medicine lost a most enthusiastic and distinguished colleague with the passing on April 29 of Dr. Cleon A. Nafe, member of the Board of Trustees of AMA and past president of the Indiana State Medical Association. He was 69.

Dr. Nafe was named to the AMA Board of Trustees and its Executive Committee in June, 1957. He had served as ISMA delegate to AMA from 1953-57, and alternate delegate in 1950-52. At the time of his death he was a member of the AMA Committee on Nursing.



The Indianapolis surgeon became president of ISMA in 1948, after having served on the Executive Committee for 12 years, 10 years of which he was chairman. Active in Hoosier medicine since 1929, Dr. Nafe held memberships on a host of ISMA committees and commissions, many of which he headed.

He was graduated cum laude from Indiana University School of Medicine in 1921, and served his internship and surgical residency at Indianapolis City Hospital, following which he was medical superintendent of that institution for four years.

Dr. Nafe had been in private practice of general surgery in Indianapolis since 1927, and served as president of both the City and Methodist hospital staffs. He was President of the Marion County Medical Society in 1946, and at the time of his death, was Associate Professor of Surgery at the Indiana University School of Medicine.

Active in the development of Blue Cross-Blue Shield in Indiana, Dr. Nafe was formerly on the Board of Directors of the National Conference on Medical Care, and was at one time a Governor of the American College of Surgeons, and President of the Indiana Chapter in 1955. He participated actively in many scientific medical programs and contributed heavily to medical literature.

In Indianapolis, Dr. Nafe was widely recognized for participating in civic affairs such as the Community Chest, Chamber of Commerce, Indianapolis Foundation, American Legion and in Masonic work.

His genial disposition, zest for hard work, interest in sports, enthusiasm for medical education and loyalty to the medical profession made him the friend of every Hoosier doctor, and the ally of all who work for the good of American medicine.

Alpha G. W. Childs, M.D.

A retired Madison physician, Dr. Alpha G. W. Childs, passed away March 30 at the age of 90.

Dr. Childs was a 1900 graduate of the Chicago Homeopathic Medical College. He was a Senior and 50-Year Club member of ISMA.

Frank E. Fisher, M.D.

Dr. Frank E. Fisher, medical director of R. R. Donnelley & Sons in Crawfordsville, passed away April 26 at the age of 63. He had also been administrator of the medical program of an ordnance plant near Laporte for 10 years.

Dr. Fisher was a graduate of McGill Medical School in Montreal, Canada.

Robert T. Hazinski, M.D.

A 47-year-old Griffith anesthesiologist, Dr. Robert T. Hazinski, passed away March 12 in Georgia, of injuries sustained in a plane crash.

A graduate of the Loyola University School of Medicine, Dr. Hazinski was in general practice in Griffith from 1940 to 1958; he moved to Gary, where he joined the Methodist Hospital staff in 1960.

DEATHS

Continued

William Franklin Johnson, M.D.

Dr. William Franklin Johnson, 79-year-old former Indianapolis physician, passed away April 9. For the past two years, he had practiced in Clermont, but prior to that time had offices in Indianapolis for over 50 years.

Dr. Johnson was a graduate of Purdue University Medical School, Class of 1906. He was a World War I veteran, and had been active in Masonic activities.

Edgar T. Mitchell, M.D.

Dr. Edgar T. Mitchell, Romney physician since 1907, passed away April 14 at the age of 81.

A 1908 graduate of Indiana University

School of Medicine, Dr. Mitchell had been retired for several years.

Mark M. Piper, M.D.

Dr. Mark M. Piper, a member of the staff at Norman Beatty Hospital, Westville, since 1958, passed away in Indianapolis April 2. He was formerly in general practice at Gary, New Castle and Rochester, and had served as Fulton County Medical Society secretary from 1930-1934.

Schuyler A. Whitsitt, M.D.

Dr. Schuyler A. Whitsitt, Senior and 50-Year Club ISMA member, passed away in January at the age of 92.

Dr. Whitsitt had served as Delegate from Jefferson County for several terms. He was a graduate of the Medical College of Indiana. ◀

County, District News

Ten District Societies Gather for Annual Meetings in May

Indiana physicians in 10 ISMA Councilor Districts gathered for annual district meetings throughout the state during the month of May.

Members of the First District Society met at Evansville May 18 for a business meeting, dinner, and to hear Mr. T. C. Peterson speak on "This, Too, is the Practice of Medicine."

Drs. Mell B. Welborn and P. J. V. Corcoran of Evansville presented the scientific program at the Third Councilor District meeting, May 11, at Huntingburg.

Meeting at Seymour Country Club May 17 was the Fourth District Society. The program included golf, luncheon, and scientific and business sessions. Speakers were Dr. Frank B. Ramsey, Indianapolis, Editor of *The Journal*, and Dr. Donald Jolly, of Muscatatuck State School.

Turkey Run Inn was chosen by the Fifth District Society for a May 17 meeting. Included on the afternoon program was golf,

historical tour, a boat ride and bowling. Evening speaker was Dr. William P. Allyn, Ph.D., "Are People Human Beings?"

Members of the Sixth District Society met at Rushville May 11 for a business meeting and scientific program, featuring talks by Drs. William D. Inlow, Shelbyville, and Stuart Bondurant, Indianapolis.

On the program for the May 17 meeting of the Seventh District Medical Society at Indianapolis was golf, a business meeting and dinner. The ladies met for luncheon and a demonstration on "Hoosier Hospitality."

Meeting at Crawfordsville May 18 was the Ninth District Society, who heard a panel on Chronic Duodenal Ulcer, with Drs. T. C. Haller, F. H. Priebe, Wemple Dodds and H. C. Wallace. Also on the program was Dr. Charles H. Brown, Cleveland Clinic, who discussed gastrointestinal disorders.

A combined 10th District Meeting and Indi-

ana Academy of General Practice Road Show took place May 10 at Gary. Scientific program speakers were Drs. Eugene Senseny and John Gogins.

Members of the 11th District Medical Society convened at Huntington May 17 for a scientific program and dinner. Speakers were Drs. Stuart Bondurant and George Lukemeyer, both of the I. U. School of Medicine.

Dr. John Furbay, Director of the Cultural and Educational Program of Trans World Airlines, spoke at the May 17 meeting of the 12th District Medical Society at Columbia City. Speaking at the business meeting were Drs. Eugene Senseny and Francis Land.

Allen

Dr. Jeremiah Stamler, of the Chicago Board of Health, spoke on "Approaches to the Prevention of Coronary Disease" at the April 4 meeting of the Allen County Medical Society. Eighty-five members were present.

Bartholomew-Brown

Twenty-three members of the Bartholomew-Brown Medical Society met at Columbus April 12 to hear the city school superintendent speak.

Cass

Dr. Dan Urschel, Mentone, spoke on heart surgery at the April 3 meeting of the Cass County Medical Society. Twenty members attended. On May 1, the group gathered to see a film on cancer detection and to discuss civil defense.

Delaware-Blackford

In an effort to further health education, members of the Delaware-Blackford Medical Society have joined forces with the *Muncie Evening Press* to present the first annual health forum in Muncie. Physicians on the program answer questions from the audience.

Floyd

Dr. Helen M. Gray spoke on "Headshrink- ing in Children" at the April 14 meeting of the Floyd County Medical Society in New Albany. Twenty-seven members were present.

Jefferson-Switzerland

Dr. Jackson W. Modisett is the newly-elected president of the Jefferson-Switzerland Medical

Society. Other new officers are Drs. Randolph Gambill, vice president; Marcella Modisett, secretary-treasurer; Frances Prenatt and Noel Graves, delegates, and Ott McAtee and A. A. Hamilton, alternates.

The group met March 7 for a discussion on protective insurance, and on Apr. 11, to hear Dr. Louis Sparmer on "The Psychiatrist in Diagnosis and Treatment."

Johnson

Dr. A. T. Chappel is the newly-elected president of the Johnson County Medical Society. Assisting him is Dr. Harry E. Mock, treasurer.

The Society met April 19 for a program on disability, old age and survivors' insurance.

Lake

Dr. George Le Roy, Associate Professor of Medicine at the University of Chicago, discussed "The Problem of Chronic Disease" at the April 12 meeting of the Lake County Medical Society. Prior to the program the group toured the new Lake County Convalescent Home.

Montgomery

Dr. Dwain Walcher, of the I. U. Medical Center, spoke on Infant Diarrhea at the April 20 meeting of the Montgomery County Medical Society at Crawfordsville.

Owen-Monroe

Twenty-five members of the Owen-Monroe Medical Society met at Bloomington April 27 to hear a discussion of plans for the new Bloomington Hospital.

Vanderburgh

At their May 9 meeting in Evansville, members of the Vanderburgh County Medical Society heard Dr. Nicholas J. Giannestras, Orthopedic Consultant for the University of Cincinnati athletic department, speak on "Athletic Injuries."

Wayne-Union

Mr. Allen Dale, representing Insurance Institute of Indianapolis, spoke to 40 members of the Wayne-Union Medical Society and several attorney-guests at a meeting April 11 in Richmond. ◀

ISMA Representative Reports on

Annual Congress of Medical Education and Licensure

President, Indiana State Medical Association
Chairman of Executive Committee, I.S.M.A.
1021 Hume Mansur Building
Indianapolis, Indiana

Gentlemen :

In accordance with instructions received from the Executive Committee the undersigned, as the chairman of the Commission on Education, attended the Annual Congress of Medical Education and Licensure, Feb. 4-7, 1961, at the Palmer House in Chicago.

From 12:30 until 6:00 P.M. on Saturday, February 4, a special meeting was held by the AMA Council on Medical Education with representatives from Chicago area state medical societies and representatives from medical schools within the area. The purpose of this session was to determine what the Council on Medical Education might do to improve their relationships with individual state medical societies and with their Commissions on Education. Each sub-chairman of the Council explained his job with the Council.

Discussion was free from the floor and it was pointed out to the Council that there appears to be no responsibility of the states in relationship to the Council and, therefore, no great amount of cooperation. A suggestion was made that possibly the Council should consider the routing of requests for information from local medical societies to the State Commission on Education and then after being acted upon by the state, this information to be forwarded on to the Council. There was also a suggestion that a recommended guide for the setting up of State Education Commissions be produced. A copy of a publication entitled "Guides to State Commit-

tees on Education," published by the American Academy of General Practice, and part of it written by the undersigned, will be used as a beginning guide. Other topics discussed concerned internships, residencies and particularly stipends.

All in all this initial meeting pointed out that the Council on Medical Education realizes that a great deal of its difficulties and problems exist because of poor communications with state medical organizations, and at least it is a beginning of a program to improve these communications. It would appear to me that possibly a letter from our state president to the chairman of the Council, Dr. McKittrick might further encourage the Council to continue its program as it is now started.

The Sunday morning program was devoted entirely to papers concerning the future of family practice. It was pointed out in these papers that the entire nation, including the patients, all segments of organized medicine and the government are deeply concerned about the shortage of family doctors. How much of a shortage there really is is shown by the statistics of the graduating class of 1950. Of this class only 15% are in general practice. The papers were interesting but offered no real solutions to the problem.

Also on Sunday various subjects were discussed. The primary question was "Is there danger of losing an appropriate balance between

the basic and clinical sciences in medical school?" A new concept in this meeting was developed and that was of conducting two simultaneous debates. These debates were most interesting and concerned pertinent subjects.

Monday morning was a general session devoted mainly to the relationship of education to hospitals, while in the afternoon the important subject of "Medical care and education in hospitals without interns or residents" was covered. The two simultaneous debates were held again on Monday afternoon.

This representative also attended a session of

the Federation of State Medical Boards of the United States concerned with discipline in the medical profession. Since the Commission on Education and the Grievance Committee of the I.S.M.A. are jointly discussing the Washington Plan, it was of interest to the undersigned that most states do not consider the Washington Plan as a good solution for disciplinary problems. This idea was obtained in private conversations with members representing other states.

Sincerely yours,

Francis L. Land, M.D., Chairman
Commission on Education I.S.M.A.

Security Not From Legislation

. . . . To us, there is a chimerical quality in that security which is supposedly gained from the provision of a pittance from a paternalistic government, by which the thread of life may be sustained for a maximum number of years. In return for this, the citizen gives up his right to earn, by his own efforts, any more than a miserable supplement to the pittance. If he is so brash as to remain an active, full time part of the gainfully employed, in defiance of the economic philosophy of the unions, he is denied the benefits for which he and his employer have paid out over the years. Those who have preferred self-reliance over dependence, and have been fortunate to have had continued opportunity for self-support, usually are among those who have inner resources contributing to a sense of security, of the sort not to be derived from any legislation or retirement dole. . . . Ian Macdonald, M.D., Editor, *Los Angeles County Medical Association Bulletin*, March 2, 1961.

Association News

EXECUTIVE COMMITTEE

April 8, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Ralph Hamill, attorney; James A. Waggenger, executive secretary.

Guests: Mrs. E. L. Rigley, president, Woman's Auxiliary to the Indiana State Medical Association; Ralph V. Everly, M.D., chairman, and Jack E. Shields, M.D., R. Case Hammond, M.D., Frederic W. Brown, M.D., Building Committee members

Membership Report

Number of members as of Dec. 31, 1960-----4,309
1961 members as of March 31, 1961:

Full due paying	3,474
Residents and interns	172
Council remitted	26
Senior	372
Honorary	3
Military	34

Total 1961 members as of March 31, 1961-----4,081

Loss over last year-----69

Number of members as of March 31, 1960-----4,150

Number of AMA members as of March 31, 1960--4,028

1961 AMA members Dues paying -----3,420

Exempt but active-----621

Total 1961 AMA members as of

March 31, 1961 -----4,041

Gain over last year-----13

Number who have paid state dues but not AMA
dues in 1961 -----40

Woman's Auxiliary

Mrs. E. L. Rigley, president, reviewed the program of the Woman's Auxiliary to the Indiana State Medical Association for the past year, and the activities of the various county auxiliaries. Dr. Wood, on behalf of the State Medical Association, expressed appreciation for the Auxiliary's fine cooperation during the Legislature.

At the request of Dr. Wood, Mrs. Rigley discussed the financial status of the Auxiliary. She reported that the Auxiliary had dues of \$1.00 for the state. She stated that the Auxiliary started in 1937 with \$1.00 membership dues and that the Indiana Auxiliary dues are much less than those of other states. The Indiana Auxiliary is operating on a budget of \$2,700.00, plus \$1,000.00 appropriated to it by the Indiana State Medical Association.

Mrs. Rigley read a letter from Dr. Culbertson which requested that the Auxiliary take the responsibility of compiling on a county-by-county basis a list of scholarships available in the health field. A letter regarding this subject, from Martin Winstead, also was read.

On motion of Drs. Owsley and Stimson the Executive Committee voted to instruct the Auxiliary to participate in this endeavor.

The Auxiliary meeting of March 29 was approved upon motion of Drs. Owsley and Covalt.

Treasurer's Office

The treasurer's report on Income, Expenses and Budget Balances as of March 31, 1961, for the headquarters office and *The Journal*, and the second quarter audit prepared by Wolf and Company, CPA, were approved by consent.

Dr. Wilkens asked for direction from the Executive Committee on investment of some of the surplus funds of the Association. On motion of Drs. Owsley and Covalt the Committee instructed the treasurer to investigate the federally-insured savings and loan associations and if he feels these are safe he is to invest some of the Association's surplus funds in these institutions.

Building Matters

Dr. Everly, chairman of the Building Committee, and Dr. Owsley each read reports on building matters, which, on motions duly made and seconded, were approved and made a part of the minutes of the Executive Committee.

REPORT OF PRESIDENT ON HISTORY AND PROGRESS OF BUILDING PROPOSAL TO BUILDING COMMITTEE AND EXECUTIVE COMMITTEE APRIL 8, 1961

Action House of Delegates, 1959

Authorization of expenditure of \$250,000. \$150,000 to be expended from general fund; \$100,000 to be financed in best way. Appointment of Building Committee to proceed with plans.

Action House of Delegates, 1960

Building Committee costs based on estimates, adopted as follows:

\$310,000 estimated cost of construction
60,000 purchase of land site
15,000 furnishings
15,000 contingencies

Adoption of financing by \$150,000 from general fund. \$125,000 to be financed best way by borrowing and balance through donations and/or purchase of building certificates in amount of \$50.00 each. Mandatory upon membership with provisions for new members stipulated.

Subsequent Action by Council

Council action rescinds mandatory provision for present members and makes contributions and/or building certificates voluntary.

Progress to Date

\$91,196.40 collected from donations and certificates.
\$35,585.00 advanced from allocations by Executive Committee toward monies to be borrowed or from general fund.
\$150,000 from bonds held by general fund.

Recapitulation :

\$ 91,196.40
35,585.00
150,000.00

\$276,781.40

Spent to date :

\$ 60,000.00 Site	\$276,781.40
3,602.60 Legal fees	65,195.60
1,593.00 Wreckage	
<hr/>	<hr/>
\$ 65,195.60	\$211,585.80 Balance

Recapitulation :

Authorized by House \$275,000 plus collection from donations and/or certificates as stated in letter by president to all members :

\$275,000.00
91,196.40

\$366,196.40
Minus 65,195.60

\$301,000.80

Site, etc. Authorized to be Spent

Borrowing potential authorized \$90,000 due to advance of \$35,000 (plus)

Net Worth Increase

1958	(Red)	9,609
1959	estimated	20,000
1960		33,500
1961	1st 6 mos.	18,250

Borrowing Possibilities

\$90,000 for 10 years at 5%

Payments	1	\$13,500	6	\$ 11,250
	2	13,050	7	10,800
	3	12,600	8	10,350
	4	12,150	9	9,900
	5	11,700	10	9,495
				<hr/>
				\$114,795 Total

\$90,000 for 15 years at 5%

Payments	1	\$10,500	8	8,400
	2	10,200	9	8,100
	3	9,900	10	7,800
	4	9,600	11	7,500
	5	9,300	12	7,200
	6	9,000	13	6,900
	7	8,700	14	6,600
			15	6,300
				<hr/>
				\$126,200 Total

The Executive Committee assured the Building Committee that it had at least \$301,000.00 available to it.

On motion of Drs. Glock and Covalt, the Building Committee was empowered to interview the decorators for opinions regarding the decorations in the building, without expense at the present time.

Dr. Glock asked the legal counsel for an opinion as to whether or not the mandatory feature of a \$50.00 payment from each new member could be enforced. Judge Hamill said that the county medical societies should be notified that the House of Delegates had ruled that new members would be required to make the \$50.00 Building Fund payment.

Legislation

National: Dr. Wood, chairman of the Commission on Legislation, discussed legislative issues currently before the Congress, primarily the King-Anderson Bill. He also discussed the plans for the Executive Committee to meet in Washington May 1, 2 and 3.

Organization Matters

The secretary read a copy of a letter addressed to the AMA concerning the appointment of an Indiana physician to the Joint Commission on the Accreditation of Hospitals.

Future Meetings

April 22-23, 1961—Fifth Annual State Convention, Medical Assistants, South Bend.

April 25, 1961—Dr. Edward R. Annis.

April 27-28, 1961—Convention, Auxiliary to ISMA South Bend.

May 1, 1961—ISMA Congressional dinner, Washington.

May 2, 1961—Indiana State Chamber of Commerce Congressional dinner.

April 30-May 3, 1961—U. S. Chamber of Commerce, Washington. By consent it was agreed the Committee would attend the Indiana State Chamber of Commerce dinner on Tuesday, May 2, and also the U. S. Chamber of Commerce luncheon on Tuesday, May 2, to hear a discussion of the health care programs for the aged.

June 25-29, 1961—American Medical Association convention, New York.

July 10-21, 1961—Training Institute, Medical Care for the Needy, Ann Arbor, Mich.

Oct. 16-20, 1961—10th Annual U. S. Civil Defense Council, Los Angeles.

There being no further business, the Committee adjourned to meet again at the Mayflower Hotel, Washington, D. C., April 30, 1961.

ASSOCIATION NEWS

Continued

THE COUNCIL

April 9, 1961

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a.m., Sunday, April 9, 1961 in the Roof Lounge, Indiana University Student Union Building, Indianapolis, with Dr. Maurice E. Glock, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Not represented

Second District—E. T. Edwards, Vincennes

Third District—John M. Paris, New Albany (also AMA alternate delegate)

Fourth District—Joe M. Black, Seymour

Fifth District—V. Earle Wiseman, Greencastle

Sixth District—Not represented

Seventh District—Ralph V. Everly, Indianapolis

Eighth District—Gordon B. Wilder, Anderson (also AMA delegate)

Ninth District—Kenneth O. Neumann, Lafayette

Albert E. Stouder, Kempton, alternate

Tenth District—James P. Vye, Gary

Ralph C. Eades, Valparaiso, alternate

Eleventh District—E. S. Rifner, Van Buren

Twelfth District—Maurice E. Glock, Fort Wayne
Milton F. Popp, Fort Wayne, alternate

Thirteenth District—Burton E. Kintner, Elkhart

Officers: Guy A. Owsley, Hartford City, president

Harry R. Stimson, Gary, president-elect

Irvin W. Wilkens, Indianapolis, treasurer

Journal: Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Don E. Wood, Indianapolis, chairman (also co-chairman, Commission on Legislation)

Wendell E. Covalt, Muncie, member

Guests: Wendell C. Stover, Boonville, AMA delegate

A. C. Offutt, Indianapolis, State Health Commissioner

Earl W. Mericle, Indianapolis, chairman, Ad Hoc Osteopathic Liaison Committee

Staff: Ralph Hamill, Indianapolis, attorney

Robert J. Amick, field secretary

Howard Grindstaff, field secretary

J. A. Waggener, executive secretary

On motion of Dr. Paris, seconded by many, the minutes of the Jan. 15, 1961, meeting of the Council were approved.

Reports of Councilors

Dr. Paris announced that the Third District meeting would be held at the Huntingburg Country Club rather than the Jasper Country Club, as previously announced.

Dr. Owsley announced, for the Eighth District, that the district meeting would be held on June 14 instead of June 7, as previously announced.

Reports of Officers

DR. GUY A. OWSLEY, president, reported that he had contacted all of the past presidents of the State As-

sociation concerning any ideas they might have whereby they might be more active in Association affairs, and the following three possibilities have been suggested:

1. That the past presidents be invited to sit in on all meetings of the Council.

2. That at least one past president be appointed to membership on each of the Association commissions.

3. That a statesmanship committee, composed entirely of past presidents, be created.

No action was taken by the Council on these suggestions.

Dr. Owsley also discussed his meeting with the Council of the Indianapolis Medical Society on April 4.

DR. FRANK B. RAMSEY, editor of *The Journal*, reported on the financial condition of *The Journal*, saying that the income and expenditures for the first six months of the fiscal year were about even. He also reported that he had been notified that he would be appointed to the Advisory Committee of the State Journal Advertising Bureau.

DR. IRVIN W. WILKENS, treasurer, presented the following report:

Each of you has been handed the Statement for the first six months of the 1961 fiscal year, prepared by our auditors, Wolf and Company. I am not going to attempt to explain in detail the report, as I believe it is clearly set forth and with the supporting data it will be easily understood by all.

I am happy to report that the Association, at the end of the first six months of its current fiscal year, has wiped out a deficit anticipated at the time the budget was prepared. During the first six months of the current fiscal year, in the General Fund, we have picked up \$1,767.99; in *The Journal* we have picked up \$12,818.22 and in the Medical Defense Fund, while not indicated in the budget, we have picked up a balance of \$3,324.06. All in all this gives us an overall gain at this point of \$17,910.27 in the black. As originally prepared, we estimated that we would be in the red in the amount of \$7,624.35. Of this \$7,624.35, estimated to be a deficit figure, \$6,091.00 was attributed to anticipated losses in *The Journal*. You will note on schedule D, that as of this point, we have picked up \$12,818.22 which wipes out the anticipated deficit of \$6,091.00 and gives us a net gain over anticipated income of \$6,727.22. Going back to my original figure of gain of \$17,910.27 and subtracting from this the anticipated red figure of \$7,624.35, theoretically, at this midway point, we are \$10,285.92 in the black for the current fiscal year.

Unfinished Business

1. **Building Committee.** Dr. Ralph Everly, chairman, presented the following report:

Your Building Committee is most happy to report, and we are sure the Council will be glad to hear, that the long, drawn-out litigation over rezoning of the property at 3935 North Meridian Street has come to an end by the granting of the complete rezoning by the Marion County Council. This means that there are now no legal obstacles in our way towards progressing with the construction of the new state office building for our Association at this site.

Your Building Committee, during the period of litigation, was hesitant to proceed with finalizing the plans for the building and the completion of the specifications for the taking of bids. The reason for this was that we were fearful that should we be unsuccessful in having the rezoning approved, and we were forced to look for another site, we could have been involved in considerable expense in the development of plans and specifications that might not be useful on any other site selected. Therefore, immediately upon the end of the litigation, your committee immediately met with the architects, and we are happy to report that the final plans are well under way.

As of this report, we anticipate the submission of the plans and specifications for bids by the first of June, and we hope that construction will be under way not later than the fifteenth of June. Our architects estimate that the building will be ready for occupancy in March, 1962.

As I am sure all of you realize, there are hundreds of details to be considered and decisions made prior to completion of plans and specifications. Your Building Committee has had several meetings with the architects to discuss these, and as of this date, we have approved the following details:

1. Elevator casing shall be in contract.
2. No ceilings in basement areas.
3. No finishing of basement areas.
4. No plumbing fixtures in basement toilets (rough-in up thru floor slab only).
5. Ceiling in work area shall be exposed grid suspension system with plastic faced lay-in panels.
6. Ceiling in administration area to be concealed suspension system (tile selection to be made at April 12 meeting).
7. Reduce Editor's office area and increase *Journal* storage area.
8. Aluminum Sun-Screen to be similar to #8 "Grill-wall" (sample shown was 6" in dia.).
9. Provisions should be made for future pass-thru door from kitchen to meeting room.
10. Ceramic tile in toilets to be ceiling height instead of wainscot height.
11. Finish first floor line shall be 5'-6" above grade.
12. Canopy shall be extruded out over driveway.
13. Windows in basement shall remain as drawn in perspective and preliminary elevations.
14. Add obscure glass panels in executive secretary's office wall behind receptionist's desk.
15. Provide for assistant secretary's office to be divided into two offices in future.
16. The use of gas for heating and cooling was discussed and tentatively approved providing that certain factors were studied further by the mechanical engineers.
17. The mechanical equipment room in basement to be increased to house cooling tower.
18. The use of individual fan coil heating and cooling units with continuous covers on outside walls.

In addition to the above, the following list represents design features which architectural engineer plans to incorporate in the project:

1. Use of special ceiling lighting in council rooms, conference room and lounge.
2. Special lobby feature wall.
3. Exterior Masonry—white marble.
4. Toilet Rooms; Wall-hung fixtures, ceiling and wall hung partitions; ceramic tile floors and walls; plaster ceilings covered with vinyl plastic fabric.
5. Wood finish movable partitions.
6. Ventilating return grills to be combined with lighting fixtures wherever possible in work areas.
7. Vinyl plastic fabric covering for ceiling areas where soil will be created by ventilating system.

FINANCING OF THE BUILDING: The Building Committee has been represented in conferences with the Executive Committee, and just last night met with them again, and as this report is being prepared for your information, we are not able to incorporate the discussion of April 8, but it will be reported in a supplemental fashion before this body.

At the meeting of the Council, during the State Convention in French Lick last October, we submitted to this body a preliminary plan for a new building, and the architect's estimate of the cost of such a building, in which he estimated an amount of \$308,200.00.

(\$308,200.00).

We then submitted to the House of Delegates a report from the Building Committee in which we pointed out that the estimates which we had received would lead the Committee to believe that we will need

(\$400,000.00).

to build a building adequate for the present and future needs of the Association.

We proposed to the House the estimate of

for the cost of construction,	(\$310,000.00)
for the purchase of the site	(\$ 60,000.00)
for furnishings	(\$ 15,000.00)
for contingencies	(\$ 15,000.00)

We further reported that, as a result of the conferences with the Executive Committee and the Council that (\$150,000.00) be taken from the securities held by the Association and that (\$250,000.00) be raised by (1) borrowing (\$125,000.00) and the balance to be raised by the purchase of repayable building certificates by the membership.

Accordingly, the reference committee and the House approved this report, and your committee has been proceeding upon this approval.

I understand you are to have before you a report of the audit of the Association in which the funds currently credited to the account of the Building Fund are as follows:

As of March 31 the following have been received:

Outright donations	(\$ 67,246.40)
Loans made to the Association	(\$ 23,950.00)
Total contributions and loans	(\$ 91,196.40)

To this has been added the money which has been accumulating to the Building Fund during the past two years in an amount equaling: (\$ 35,585.00)

This, then, makes the cash account total (\$126,781.40)

To this is to be added the (\$150,000.00) in securities.

This, then, brings our total cash, plus securities allocated to: (\$276,781.40)

EXPENSES: As of March 31 we have paid from this account the following:

Purchase of ground: (\$ 60,000.00)
Legal fees, including transcript of legal proceedings: (\$ 3,602.60)
For removal of buildings on the premises: (\$ 1,593.00)
Making the total expenditures, as of the 31st of March: (\$ 65,195.60)

If your Committee is correct, this leaves to the credit of the Building Fund, a balance of cash, plus securities in an amount equaling (\$211,585.80)

If we are to use the full limitation of (\$400,000.00) as authorized by the House of Delegates, we can deduct (\$2,500.00)

from the architect's original estimate of (\$308,200.00) as that amount represents the figure he estimated it would cost to remove the buildings from the premises for which we are accomplishing for an amount of (\$ 1,593.00)

This would bring his estimate then down to (\$305,700.00)

Subtracting the cash and securities available from this amount, and should we find it necessary to expend the limit of (\$400,000.00) this would mean that we would go into the market for a loan of (\$ 94,414.20)

We are, naturally, hopeful that as the word spreads throughout the state that construction is actually under way that some of those who have not contributed will do so, and we further hope that we will be in a position to obtain bids which will total much less than the architect's estimate, so that it will not be necessary for the Association to borrow the above amount. The architects are encouraging in that they state that at the time we will be asking for bids on the construction it will be very favorable to obtaining some keen competition for the cost of this building.

We trust that this report will meet with your approval, and we want to, at this time, express our appreciation to the Council and to the Executive Committee and to the officers of this Association, as well as the membership in general, for their valuable assistance and support, and we hope that we shall accomplish a job which will meet with the approval of all.

Ralph V. Everly, M.D., *Chairman*
Frederic W. Brown, M.D.
R. Case Hammond, M.D.
Harry Pandolfo, M.D.
Jack E. Shields, M.D.

On motion of Drs. Black and Stimson, the Council commended the Building Committee for the work it has done and for the report presented by Dr. Everly.

2. **Student Loan Fund.** (a). In the absence of Dr. Harry Ross, Dr. Owsley called attention to the fact that \$33,531.90 has been loaned to students, leaving a balance in the \$40,000.00 fund appropriated for this purpose of \$6,469.00 still available for loans. Applica-

tions have been numerous since the legal limit in the loan fund was increased to \$40,000.00.

(b). A plan, formulated by the Indianapolis banks for lending money to students, was explained by Mr. J. Hugh Funk of the Indiana National Bank and Mr. W. W. Hill, Jr., manager of United Student Aid Funds, Inc. On motion of Drs. Black and Paris, the Council referred this matter to the Committee on Student Loan for study and report at the next Council meeting.

3. **Medical Care for Military Dependents.** Mr. Waggener reported 639 claims, totaling approximately \$38,000.00, had been processed in March.

Dr. Stimson stated that Indiana's plan of attempting to allow a reasonable and usual fee, instead of following a rigid fee schedule, has been adopted by a number of the other states.

4. **Liaison Committee between Council and Blue Shield.** In the absence of Dr. Challman, chairman, Dr. Paris reported that the Blue Shield Board at its January meeting approved a \$250.00 plan. "We now have a \$200.00 plan, the standard plan, the new \$250.00 plan, and a \$300.000 plan, which is the present Brown Book or preferred schedule, which has been in effect for some years. It is believed by the Board that this will solve some of the problems of being more nearly able to indemnify the patient, in certain areas of the state, where the doctors' fees are half way between the standard and the preferred schedule. . . . The Board reported that many groups have converted from the standard plan to the preferred plan. . . . I think the effect of the liaison committee on the Blue Shield Board has been very stimulating and I think the committee should be continued."

5. **Osteopathic matters.** Report of the Ad Hoc Osteopathic Committee, consisting of Drs. Earl W. Mericle, chairman, B. E. Kintner, K. O. Neumann, and E. T. Edwards, covering three meetings of the committee—Jan. 15, Jan. 29 and March 19, 1961, was read to the Council by Dr. Mericle. Discussed by Drs. Paris, Kintner, Owsley, Neumann, Stover, Edwards, Wood and Stimson.

On motion of Drs. Stimson and Owsley the Council voted that the Ad Hoc Committee shall continue to function.

Legislative Matters

Dr. Don E. Wood, co-chairman of the Commission on Legislation, reported on the Commission's activities during the 92nd General Assembly. He spoke of implementation of the Kerr-Mills Bill by expanding the present old age assistance program, effective January 1962.

On motion of Drs. Paris, Wilder and Stimson, the Council gave a vote of thanks to the Commission on Legislation and the headquarters staff for their work during the Legislature.

Economic and Organization Matters

1. **Remission of state dues.** The Council voted remission of state dues as follows:

Allen County—one member, due to illness and retirement, on motion of Drs. Popp and Rifner.

Daviess-Martin County—one member, because of illness and hardship, on motion of Drs. Edwards and Vye.

Marion County—one member, due to retirement, on motion of Drs. Wilkens and Popp.

Wells County—one member, who is a medical missionary, on motion of Drs. Stimson and Paris.

2. **Membership report**, as of March 31, 1961, showing a loss of 69 members over the same time last year and a total membership of 4,081, was noted.

New Business

1. **Matters referred to Council by Executive Committee.**

a. **SURVEY OF HOSPITAL ADMISSIONS OF PERSONS OVER 65**, with breakdown as to those who were able to pay from their own assets, or whether assistance was required in the payment of their bills, and if so, how much, by whom, in what manner, and what need they actually showed.

Dr. Wood asked for the consensus of the Council as to whether or not this survey should be instituted by the State Medical Association in the hospitals of the state by having the doctors ask the administrators to help with such a program. Discussed by Drs. Paris, Edwards, Vye, Stimson, and Offutt, with Dr. Offutt offering the assistance of the State Board of Health.

On motion of Drs. Stimson and Edwards the Council approved of such a survey and went on record as requesting the State Board of Health to make the survey at the same time as the State Board makes a hospital license survey.

b. **ACTION OF HOUSE OF DELEGATES OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA.**

On motion of Drs. Black and Kintner the Council voted to propose to the House of Delegates of the Indiana State Medical Association a resolution similar to the following action which was passed by the Medical Society of North Carolina:

MEDICAL SOCIETY OF THE STATE OF
NORTH CAROLINA

CURRENT RESTATEMENT OF POLICY
ON LEGISLATION

WITH MEDICAL IMPLICATIONS.

WHEREAS, the Congress of the United States has for several sessions considered various bills relative to providing and subsidizing the sickness costs of the aging, and

WHEREAS, the physicians of the State of North Carolina consider such bills to be socialized medicine for a large but special group of our population, and

WHEREAS, the estimated cost for any of these plans is astronomical and unpredictable, and

WHEREAS, the vast majority of individuals over the age 65 do not require federal assistance, and

WHEREAS, in North Carolina physicians have always contributed their services to the care of the indigent and semi-indigent of all ages, and

WHEREAS, extensive studies on county levels in North Carolina have failed to demon-

strate any degree of unmet needs which would warrant Federal participation in providing care for any age group, and

WHEREAS, it is the desire of the members of the Medical Society of the State of North Carolina to improve the medical care for all persons, and

WHEREAS, the members of the Medical Society of the State of North Carolina feel that political medical practice would hinder and not improve this medical care

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Society of the State of North Carolina meeting in annual session in the City of Raleigh, North Carolina, this the ninth day of May 1960 commend those members of the Congress and all others who have maintained a steadfast opposition to furthering the cause of socialism, and

BE IT FURTHER RESOLVED, that, the American Medical Association's positive eight point program for the care of the aging be endorsed, publicized, and efforts at implementation expanded, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the President of the United States, the Vice-President of the United States, the Speaker of the House of Representatives, the members of the House Ways and Means Committee, the Secretary of Health, Education and Welfare, the Governor of the State of North Carolina, the Honorable members of the North Carolina Congressional Delegation, the members of the Board of Trustees of the American Medical Association and to all State Medical Societies.

(The above constitutes an action of the House of Delegates of the Medical Society of the State of North Carolina as it existed on March 1, 1961.)

On motion of Drs. Black and Vye the Council instructed the AMA delegates from Indiana to support this resolution at the AMA level.

c. **AMA DUES INCREASE.** Dr. Wood read the following resolution, which was adopted by the House of Delegates of the Nebraska State Medical Association on February 19, 1961:

WHEREAS the American Medical Association is in need of an immediate, continuous, and positive all-out Public Information campaign conducted by an outside agency specializing in this field; and

WHEREAS the House of Delegates of the American Medical Association will be asked to approve a \$20.00 increase in dues in June, 1961;

THEREFORE BE IT RESOLVED that the Nebraska State Medical Association does not approve this increase in dues if the above indicated campaign is not initiated and carried out at once; and

BE IT FURTHER RESOLVED that this increase in dues shall be reviewed in three years, and cancelled if unnecessary for the purpose for which it was initiated; and

BE IT FURTHER RESOLVED that a copy of this resolution be distributed at once as follows:

1. Board of Trustees, American Medical Association
2. For introduction into the House of Delegates of the American Medical Association
3. Every state medical society
4. All county societies in the United States in large metropolitan areas

Discussed by Drs. Stover, Paris and Kintner.

The chairman read the mimeographed memorandum from the AMA entitled, "You Have a Right to Know."

Further discussion by Drs. Vye, Owsley and Paris.

It was taken by consent that a copy of "You Have a Right to Know" should be sent to every physician in the state, with a request for comments from each member, and also that this subject be discussed at the spring district meetings.

On motion of Drs. Stimson and Owsley, the Council voted to send the AMA delegates to the New York AMA meeting in June uninstructed on this subject.

An unofficial poll of the Council members showed eleven councilors in favor and one opposed to an increase in AMA dues.

d. BUILDING MATTERS.

(1) Cut-off date for refund of building fund contributions. On Motion of Drs. Paris and Kintner, the final date for making refunds of donations to the building fund was set as of April 9, 1961.

(2) Mandatory \$50.00 payment to Building Fund by new members. On motion of Drs. Owsley and Paris the Council instructed the secretary to notify the county medical society secretaries that all new members must pay \$50.00 into the Building Fund, in addition to the regular State Association dues of \$50.00, in accordance with the action previously taken by the Council and the House of Delegates.

2. **Woman's Auxiliary.** The chairman of the Council reported that the president of the Woman's Auxiliary had met with the Executive Committee to discuss the Auxiliary's financial problems, and the Executive Committee had requested the Auxiliary to revise its dues structure as soon as possible, inasmuch as the Indiana State Medical Association cannot continue indefinitely to subsidize this organization. He asked that each councilor assist and advise the Auxiliary in any way possible in order that a dues increase may be accomplished.

3. **Grievance Committee.** In the absence of Dr. Philip B. Reed, the chairman announced that Dr. Reed had asked that the councilors report to the Grievance Committee any injustices in instances where physicians employed by hospitals or groups are discharged rather abruptly.

The secretary reported that the two cases discussed by Dr. Reed at the midwinter Council meeting had been referred to the county medical society involved and the Grievance Committee had been informed that the cases should be stricken from its records.

4. **Dr. John D. VanNuys, Dean, I. U. School of Medicine,** reported that Indiana University School of Medicine had received additional money for operation

for both years from the last Legislature, which will permit some salary adjustments in academic and non-academic personnel. The school plans to admit 205 freshmen in September, which means that at least one additional teacher in each of the six basic departments will be needed, and this increase in staff is not provided for in the budget approved by the General Assembly.

The Legislature also appropriated \$300,000 for repairs of the existing plan and \$2,000,000 to start a new teaching hospital for adult patients.

The Riley Hospital Association has appropriated \$600,000 for improvements to Riley Hospital, and this was almost matched. \$400,000 was appropriated by the General Assembly, which totals \$1,000,000, to construct new operating rooms and a rehabilitation department at Riley.

Dr. VanNuys stressed the great need for student loans and expressed interest in the proposal for handling student loans, which was presented to the Council by officials of the Indiana National Bank and the United Student Aid Funds, Inc. He also spoke of the increase in fully paid scholarships, to which he and Indiana University School of Medicine officials are opposed. "We have consistently tried to keep tuition as low as possible—it is lowest or next to lowest of all the schools in the United States. I still believe, with a low tuition, plus some working opportunities, particularly for the juniors and seniors, plus all the student loan help that we can find, that this is by far the better answer to this problem. Students really must be motivated to a certain extent to help themselves rather than to receive an all-out handout."

5. State Board of Health Matters.

a. **DR. OFFUTT REPORTED** on recent legislation which abolished the Department of Health and redistributed its responsibilities to the State Board of Health. Personnel transfers and the shifting of the medical institutions to the Board of Health have begun.

b. **PHENYLKETONURIA LAW.** The educational program required by this new law has not been begun as yet. Report on this planning will be made at a later Council meeting.

c. **POLIO VACCINATION PUBLICITY.** Dr. Offutt outlined the publicity program which the State Board of Health would like to inaugurate with the assistance of the Indiana State Medical Association. "We have estimated that about 40% of our population has no family physician and to date these people have not been reached by any of the usual announcements on the radio or in the public press. There were 27 polio cases in Marion county last year and 16 to 18 of those were clustered in one part of Indianapolis. Many of these cases were within two to three blocks of the dollar clinics held here, which means that for some reason we are not getting to these people at all. We would like to launch a program of publicity toward getting this 40% that now exists, who are unvaccinated entirely, getting something done toward getting them into a physician.

"We would like to send out a technical bulletin to all physicians describing the status of the oral vaccine as against the formalin inactivated vaccine.

"We would like to ask that a letter go to all component county societies, which, if done, would be signed by Dr. Owsley and me, asking and urging them to cooperate and to give every facility toward the establishment of some kind of a vaccine program."

Dr. Offutt's proposal was discussed by Drs. Wood, Neumann, Edwards and Vye.

6. Publicity program regarding Salk vaccine. Dr. Rifner presented the following resolution, which **on motion of Drs. Rifner and Edwards was adopted by the Council:**

RESOLVED that a letter be sent to all county medical societies from the Indiana State Medical Association and the State Board of Health to spearhead information programs on vaccination;

RESOLVED that technical information be given to all physicians regarding the status of live versus inactivated vaccine;

RESOLVED that a letter be sent from the Indiana State Medical Association and the State Board of Health to the local medical societies and health officers, to work with local clubs to coordinate activities in vaccination programs;

RESOLVED to release to informational media in the name of the Indiana State Medical Association and the State Board of Health data on the need for early immunization—do not wait for oral vaccine;

RESOLVED, to ask the county medical societies to inform the State Board of Health of any and all programs organized and sponsored by them.

Discussed by Drs. Rifner, Paris and Kintner.

7. Nominations for two Editorial Board members, to succeed Drs. Harold D. Lynch and Jene R. Bennett, whose terms expire Dec. 31, 1961, were deferred until the next meeting of the Council.

8. Blue Shield Board members.

a. Attention was called to the expiration March 1, 1962, of Blue Shield Board members from the First, Fifth, Eighth, Ninth and Twelfth Districts, nominations to fill these Board memberships to be made by the respective districts.

b. Nomination of one member-at-large, to fill the three-year term starting March 1, 1962, was deferred until a later Council meeting.

By consent, July 9, 1961, was set for the summer Council meeting.

There being no further business, the meeting was adjourned. ◀

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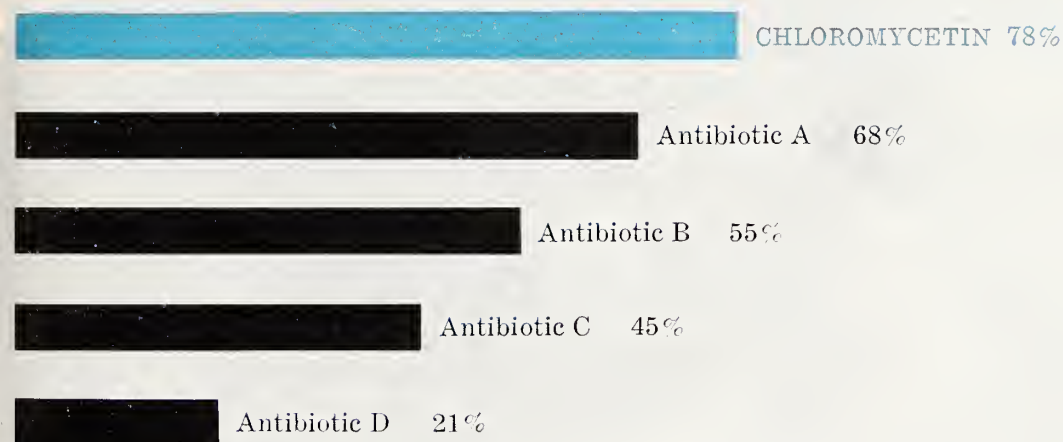
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References: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J. A. M. A.* 173:475, 1960. (2) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (3) Cohen, S.: *Circulation* 20:96, 1959. (4) Edwards, T. S.: *Am. J. Ophth.* 48, Part II:19, 1959. (5) Smith, I. M.: *Staphylococcal Infections*, Chicago, The Year Book Publishers, Inc., 1958, p. 148. (6) Petersdorf, R. G.; Rose, M. C.; Minchew, H. B.; Keene, W. R., & Bennett, I. L., Jr.: *Arch. Int. Med.* 105:398, 1960. (7) Editorial: *J. A. M. A.* 173:544, 1960. (8) Finland, M.; Jones, W. F., Jr., & Bennett, I. L., Jr.: *Arch. Int. Med.* 104:365, 1959.

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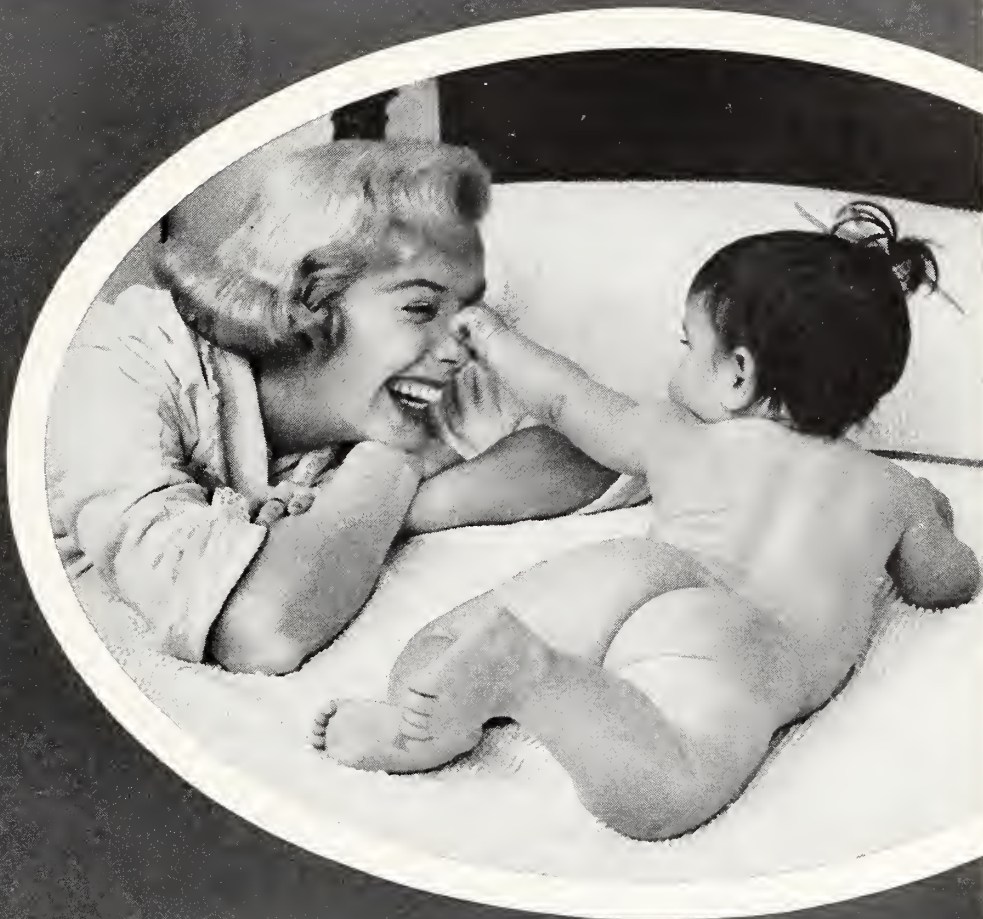
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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

The American Medical Association supported the Kennedy Administration's proposal to provide \$750 million in matching funds for construction of medical, dental, public health and osteopathic schools.

In a letter to Sen. Lister Hill (D., Ala.), Chairman of the Senate Labor and Public Welfare Committee, Dr. F. J. L. Blasingame, Executive Vice President of the A.M.A., said:

"As an Association of 179,000 practicing physicians, we are vitally interested in maintaining the high quality of medical education in the United States because of its direct relationship to medical care. For over a century, the American Medical Association has been actively and effectively engaged in the improvement of medical education in the United States. It can now be said, with assurance, that medical education in this country is superior to that found anywhere else in the world. It is not a coincidence that the improved standards of medical care in the last half century saw the elimination of sub-standard medical schools and diploma mills which had been turning out graduates in large numbers. This improvement in medical education is the result of the vigorous efforts of this Association and other interested organizations.

"We strongly believe that increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education if high standards of medical education are to be maintained. Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. We are of the firm conviction that increase in the physical facilities available for medical education should be given priority at this time over any other federal legislation in the field of medical education.

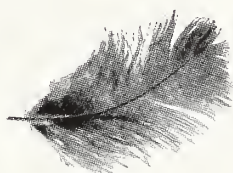
RECOGNIZE NEED FOR ASSISTANCE

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools and, therefore, a one-time expenditure of federal funds on a matching basis, where maximum freedom of the school from federal control is assured, is justified."

The AMA opposed a provision that might encourage medical schools to expand too rapidly. Dr. Blasingame said: "It is quite possible that a forced increase in freshman enrollment would be detrimental to the quality of medical education."

Continued on page 996

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References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy 18:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, in press. 3. Shaftel, H. E.: Clin. Med. 7:1841 (Sept.) 1960.



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MONTH IN WASHINGTON

Continued from page 990

The Association didn't take a position on the provision of the Administration legislation that would provide federal scholarships to medical students. However, Dr. Blasingame described to the Senate committee AMA's new medical scholarship and student loan programs.

The General Accounting Office found the Defense Department's Medicare program being conducted generally "in a satisfactory manner," but recommended some changes designed to correct what it considered "important deficiencies."

The Army, which administers the program of medical care for dependents of members of the armed services, took steps to put into effect most of the recommendations of the GAO, which audits federal spending for Congress.

However, Medicare officials rejected a GAO proposal for a change in physician fees.

"Our review disclosed that physicians' claims for medical care are, in general, significantly higher in states where maximum fees are made known to physicians than in those states where maximum fees are not made known," the GAO reported. "We estimate that there is an additional cost of as much as \$3 million to \$4 million annually as a result of maximum fees, rather than normal fees, being charged in the states where fee schedules are distributed to the physicians."

The GAO recommended that lower fixed fee schedules be negotiated for states where a high percentage of physicians' claims are for maximum allowable fees, "subject to being raised only on the basis of clearly supported evidence of higher normal fees."

If lower fees cannot be negotiated, the GAO said, efforts should be made "to have the state medical society or other appropriate parties accept the responsibility for determining that physician claims are generally not in excess of their normal charges."

The GAO further recommended that "physicians be required to certify on each claim that the amount billed does not exceed the physician's normal fee for the medical care furnished."

The Army disagreed, saying that it believed "the present contracting concept is the most suitable to meet the requirements and is in the best interests of the government."

The AMA noted that it had held from the outset that "fixed fee schedules would result in a more expensive program than if physicians were permitted to charge their normal fees."

Fixed fee schedules call for some fees above some so-called normal fees and others below average fees, the AMA said, "physicians tend to 'balance out' by using fees listed in the fixed fee schedule."

Medicare was started December 7, 1956. During the first four years of the program, \$130 million was paid to civilian doctors and \$133 million to civilian hospitals for care of 1.1 million military dependents. Maternity cases accounted for about half the total.

Medicare has asked Congress for \$73.2 million for the fiscal year 1962 beginning this July 1. This is a \$6.9 million increase over Medicare's current budget. The increase is needed, Medicare said, because of more military dependents eligible for the program's benefits and increases in the costs of services.



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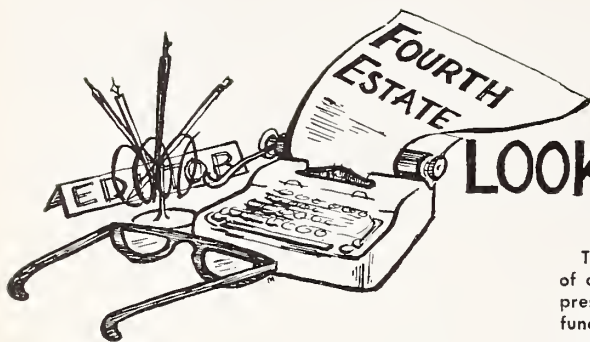
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Unhealthy Medicine

When President Kennedy proposed his plan of medical care for the aged last February, there were promises galore of what the government would do for some 14 million of the nation's old people—but no mention of what keeping those promises might cost.

Necessarily, the Administration had to come up with some figures. So it proposed a boost in the Social Security payroll tax estimated to yield \$1.5 billion. But no one pretended that precisely \$1.5 billion was the price-tag of the medical program's first year. It was a guess, and the planners have been second-guessing themselves ever since, with revealing results.

As this newspaper reported the other day, a refiguring of a part of the President's plan—nursing home benefits—has produced a new cost estimate millions of dollars higher than the original. Well, one might say, a slip or two is to be expected in such a vast and novel undertaking. But it happens that the miscalculation of the cost of one medium-sized promise could raise government outlays by 9% and throw the program's whole financing scheme out of whack.

Instead of the originally predicted \$9 million, Social Security planners now figure nursing home benefits might cost somewhere between \$25 million and \$225 million the first year, with \$100 million regarded as a likely sum. If the poor guesswork on just this one aspect of the medical care program is any indication, the Administration's cost-estimating for the program as a whole will fall far short of the real tax costs.

That has been the experience of every nation which has plunged into Government medical care. In Great Britain, for example, the Na-

tional Health Service, despite criticism of its inadequacy, costs three times the original estimates.

It's one thing to try to help the relatively few old people who are truly needy. It's quite another to compel all the people to pay incalculable costs for this unhealthy Federal medicine.

Wall Street Journal
May 29, 1961

Medical School Possibility

Can South Bend become the site of a medical school? Dr. Albert C. Furstenberg, former dean of the University of Michigan Medical School, thinks the city has a better than fair chance of doing that if it sets its sights on the objective and goes to work.


Indiana "unquestionably" is going to need another medical school, Dr. Furstenberg said in an address to the Woman's Auxiliary of the Indiana State Medical Assn. in South Bend last week.

His opinion might have elicited little more than passing local interest had he not added that South Bend appears to be as logical a location for such a school as any city in the state.

His suggestion fires the imagination. Here is the way he sees it: "Facilities in Indiana for medical education may be adequate now, but more medical manpower will be needed in the future if we're to continue to do a better job in the practice of medicine.

"It takes at least a decade for a new medical school to start producing practicing doctors—a year to plan the school, two to build it, a year to recruit a faculty, four more to graduate the first class, another year for internship and possibly another for specialization."

Continued



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(carisoprodol, Wallace)

 Wallace Laboratories, Cranbury, New Jersey

FOURTH ESTATE

Continued

Then he asks, "So why not start planning now?" Indeed, why not?

If, as Dr. Furstenberg says, Indiana is going to need another medical school, it is reasonable to conclude that if one is established it will go to a community that wants it and which has attractive assets to make it attractive.

Dr. Furstenberg, who has the experience to speak with authority, makes it clear that he thinks South Bend has things that make the city appealing as a site.

With this to go on, South Bend should lose no time in exploring the possibilities of becoming the site of a medical school and exploiting the assets to the fullest.

As Indiana University, which has a medical school in Indianapolis, is investing a substantial sum in a South Bend-Mishawaka Extension Center a second I. U. medical school in South Bend might be feasible.

South Bend has an enviable reputation as a medical center of growing importance in this part of Indiana. This would be a strong point in its favor in bidding to become the site of a new medical school, either in connection with I. U. or independent of it.

We ought to begin acting to make certain that our chances for success do not suffer from lack of interest on the part of civic, medical and political leaders.

South Bend Tribune
May 5, 1961

Hats Off to Kiwanians

In the two and one-half years that the Kiwanis Diagnostic and Outpatient Center has been in service at the James Whitcomb Riley Hospital for Children in Indianapolis it has recorded more than 60,000 visits by sick and crippled boys and girls from all communities of Indiana. This was a highlight of the annual report just made to the Indiana District of Kiwanis International by Perry W. Lesh, president of the James Whitcomb Riley Memorial Association.

The Kiwanians of Terre Haute and of the State of Indiana, in a voluntary program among the individual members of local clubs, have subscribed nearly \$70,000 which has been used to provide the most modern medical and surgical equipment for the outpatient center.

When Kiwanians started this magnificent program they did so in the belief that it would be in the best tradition of their historic regard for less fortunate boys and girls. The great numbers of handicapped children who have benefited from the generosity of Kiwanis is heart-warming evidence of the correctness of that belief.

The Kiwanis Center at the hospital has enabled service to increasing numbers of children by provision of added facilities and, at the same time, has made it possible to care for patients with multiple disabilities without the necessity in many instances of so many repeated trips to the hospital from distant points of the state.

The impetus which the new facility has given to the hospital's outpatient program is illustrated by statistics which show that the number of outpatient visits for the last reporting year was the highest in history—8,000 more than two years ago.

The Kiwanis Center, is the locale for nearly 25 outpatient clinics treating such diseases and disabilities of children as: heart ailments, club feet, muscular dystrophy, multiple sclerosis, tuberculosis, epilepsy, cleft palate, those with intellectual handicaps, victims of neuro-surgical disorders, those needing plastic surgery and many others. The children are referred to the Kiwanis Center at the hospital by local physicians from every county of Indiana for the specialized services available.

Terre Haute and Indiana Kiwanians undertook their voluntary program when they learned that demand for outpatient services at Riley Hospital had increased by nearly 100% in the last 10 years. This marks the second time that Kiwanis Clubs in Indiana have come to the aid of the handicapped boys and girls of Riley Hospital. More than 30 years ago Kiwanians built the Kiwanis Wing which has provided bed-patient service to more than 12,000 child patients.

The clubs are to be highly commended for these accomplishments.

Terre Haute Tribune
March 15, 1961

Gains for Mentally Retarded

Indiana's emphasis on helping retarded children has received the warmhearted approval of the people of the state. The work that has been done in Kokomo to provide more educational

Continued on page 1004

Primary Pulmonary Hypertension: Obstetrical Anesthetic Death

ROBERT W. CHRISTIE, M.D.*

Muncie

UNEXPECTED DEATH followed cyclopropane anesthesia during labor in a young woman who had an infrequently occurring, poorly understood disease, primary pulmonary hypertension.^{1,2,3} At least one other case has been published² in which a pregnant woman developed progressive dyspnea, left vocal cord paralysis, and severe weight loss associated with excessive nausea and vomiting before death. Whether these signs represent a syndrome remains to be seen, but in each instance a diagnosis of "obliterative pulmonary endarteritis" with right heart dilatation and hypertrophy was established at autopsy, and clinically, the disease was classifiable as primary pulmonary hypertension.

Case Report

An 18-year-old white married woman, gravida II, para I, was admitted to the hospital because of weakness, weight loss, hoarseness and exertional shortness of breath. During the second trimester of the pregnancy, nausea and vomiting had occurred, which became increasingly severe and resulted in an estimated 30 lb. weight loss. The patient had noted hoarseness two weeks be-

fore hospitalization and thought it to be due to laryngitis, but due to soreness of the neck she was referred to an otolaryngologist who found a partial paralysis of the left vocal cord. The hoarseness did not improve and it was thought that she had a lesion involving the left recurrent laryngeal nerve.

A review of her previous hospital charts showed that she was admitted to the hospital at the age of eight months for severe infectious diarrhea. A normal physical examination was recorded and she received sulfa drugs as well as a transfusion of 100 cc. of compatible (as determined in 1941) whole blood because of the severity of the illness. She was discharged fully recovered.

Pyuria was the cause for a second admission to the hospital when she was six years old, and in the interim she had had chickenpox but no prophylactic immunizations. Physical examination disclosed no abnormalities. Pyelitis consequent to a congenital defect of the renal system was suspected.

When in the eighth grade at school, she was restricted from full participation in the physical education program because of some shortness of

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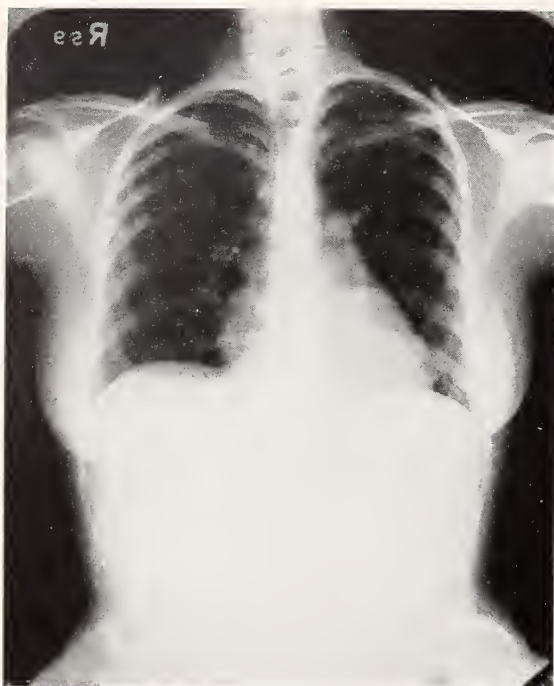


FIGURE 1
POSTERO-ANTERIOR film of the chest, demonstrating a prominent pulmonary artery segment on the left cardiac border.

breath after prolonged exertional activity. The nature of this difficulty was never evaluated.

On the third admission to the hospital at age 15, the patient was delivered of a full term infant. After being taken to the obstetrical ward post-partum she was found to have a blood pressure of 152 systolic, 118 diastolic. A slight elevation of blood pressure was detected on the first post-partum day as well.

Final Admission

Systemic review at the time of the final admission revealed no further cardiovascular symptoms, the patient apparently having forgotten her restrictions at school. The pregnancy had been otherwise uneventful.

Physical examination disclosed a white woman who did not appear acutely ill. There was no cyanosis and she spoke with a hoarse voice. The eye grounds were normal, and the upper respiratory passages were clear. Her lungs were also clear to both percussion and auscultation, and the heart rate was 110 with a regular rhythm. Blood pressure was 95 systolic and 70 diastolic. The point of maximum cardiac impulse was felt at the 4th intercostal space in the midclavicular line, and there was a grade III systolic murmur heard in the mitral area as well as a low-pitched

diastolic rumble. There was a systolic blowing murmur over the pulmonic valve and an accentuated second pulmonic sound. There were no precordial thrills, and the peripheral pulses were normal. Height of the fundus suggested a 22 to 24 weeks pregnancy. The remainder of the examination was within normal limits. By chest x-ray as well as by fluoroscopy she was found to have a prominent pulmonary artery segment on the left cardiac border (Figure 1).

A medical consultant examined her in the hospital and thought she had rheumatic heart disease with mitral stenosis and mitral insufficiency, pulmonary hypertension and partial vocal cord paralysis due to cardiac pressure on the recurrent laryngeal nerve. He advised digitalization, which was carried out. An electrocardiogram two days after admission revealed "digitalis effect and/or myocardial damage, and a right axis deviation." Urinalysis was normal, and the blood hemoglobin was 14.1 grams with one normoblast noted per 100 leukocytes in an otherwise normal differential count. Despite a week of bed rest in the hospital, nausea and vomiting persisted and weight loss became apparent. False labor began, persisted for 24 hours, and subsided.

Bronchoscopy Completed

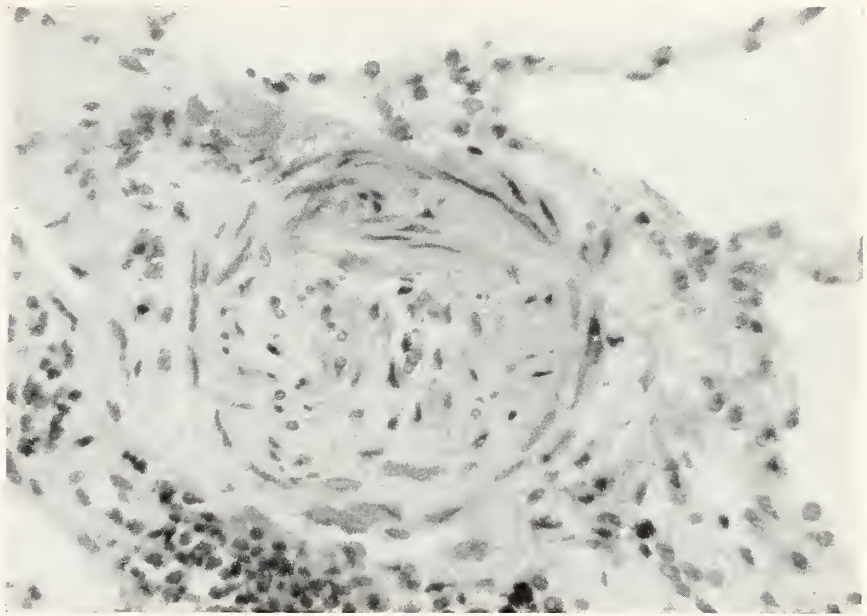
Sixteen days after admission bronchoscopy was scheduled but not completed because a systolic blood pressure above 75 mm. of mercury could not be obtained prior to anesthesia. Three days later bronchoscopy was successfully carried out under pentothal-nitrous oxide-oxygen anesthesia. No abnormalities of the tracheo-bronchial tree were noted. Cytological smears of bronchial material contained no abnormal cells.

The patient was discharged from the hospital, and readmitted one week later with a chief complaint of nausea and vomiting. While at home she had remained in bed but had continued to cough and spit blood. Physical examination then showed no change except that she looked thin and depressed. She seemed to be improved after three days of rest and was discharged.

A month later, at approximately the seventh and one-half month of pregnancy she was admitted to the hospital in labor. Her temperature was 96.8°, pulse 100, and respirations 20. The blood pressure was 94 systolic, 70 diastolic. She had desultory labor pains for 20 hours, and during this time the fetal heart tones were normal. Thereafter labor became more active and 24

FIGURE 2

HIGH POWER SECTION of the lung showing arteriole with lumen almost obliterated by medial hypertrophy and intimal hyperplasia (hematoxylin and eosin stain).



hours after labor began, Demerol 75 mg., and hyoscine 0.4 mg. were given. About six hours later the patient was brought to the delivery room.

Cyclopropane, nitrous oxide and oxygen anesthesia were given by a nurse anesthetist and after a few moments no pulse or blood pressure was obtainable. Anesthesia was thereupon stopped. The maternal heart tones were only faintly audible. About 20 minutes later a baby weighing 3½ lbs. was delivered, viable and in good condition. The placenta followed in two minutes, and methergine 0.2 mg. was given intramuscularly. Levophed in normal saline drip was started intravenously. Soon afterward no heart sounds could be heard. A surgeon consultant opened the chest and massaged the heart but this proved useless.

At autopsy there was right atrial and right ventricular dilatation. The heart weighed 320 gms (stated maximum for sex, age and weight is 255 grams⁵). There was no valvular disease, congenital abnormality or mural thrombus. The ductus arteriosus was a fibrous band. The right lung weighed 245 gms, and the left lung weighed 170 gms. There were multiple subpleural and parenchymal hemorrhagic areas up to 0.5 cm in diameter. The pulmonary arteries were dilated excepting the more terminal portions, where most of the arteries narrowed abruptly approximately 1.0 cm. from the pleural surface. There was definite minimal atherosclerosis of the major

pulmonary artery segments. The pulmonary artery and aorta were equal in thickness. There was a right hydroureter, apparently due to obstruction by kinking at the level of the broad ligament.

Recent Hemorrhage

On microscopic examination of the lungs there were areas of recent subpleural hemorrhage amongst which were arterioles with lumina almost obliterated because of intimal and medial hyperplasia and hypertrophy (Figure 2). The pathological changes were limited almost exclusively to vessels less than 100 μ in diameter (Figure 3), although a few large, histologically normal blood vessels contained thrombi which were not organized and were thought to be agonal in origin. There were areas in the lung with small infarcts of various ages, with a few showing resolution. Some of the infarcted areas also contained centrally-located vessels with complete obliteration of their lumina by medial hypertrophy and endothelial hyperplasia. No areas of infarction greater than 0.5 cm were seen, and the infarcted areas appeared to be secondary to the vascular narrowing rather than the result of emboli. While many of the involved arterioles were immediately adjacent terminal and tertiary bronchi, some were present in the lung without proximity to any of the parabronchial structures.

There was no histologic evidence of pulmonary fibrosis. Sections of the heart revealed

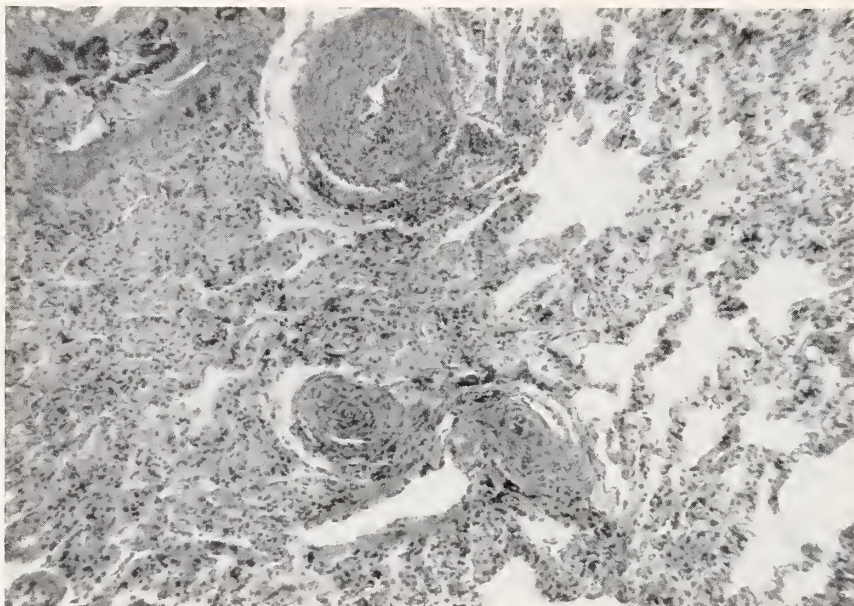


FIGURE 3
SECTION OF THE LUNG showing changes similar to those in Figure 2 in the smaller arteries, without evidence of thrombosis. (Hematoxylin and eosin stain.) Arteries larger than 100 μ were normal.

hypertrophy of the myocardial fibres and occasional areas with extravasated erythrocytes, many of which were laked, while adjacent macrophages contained blood pigment. There was no evidence of rheumatic or "collagen" disease. Examination of the pelvic organs revealed no vascular abnormalities. No source of emboli was found. The pathologic diagnosis was obliterative pulmonary endarteritis.

Discussion

Muirhead, Montgomery and Gordon² reported two autopsied cases, the first being so remarkably similar in symptoms and autopsy findings to the case presented here that the resemblance is striking. Each of these women noted the onset of symptoms during pregnancy. Each had increasing dyspnea, each had weight loss associated with nausea and vomiting, and each had left vocal cord paralysis without clinical or pathological proof of primary lung or heart disease.

It is typical in many of the recorded cases of primary pulmonary hypertension that the onset is early in life, and Muirhead, Montgomery and Gordon's first case is one of a small number of authentic cases reported in adults in which no other disease state is evident (Muirhead, Montgomery and Gordon's second case was associated with cryoglobulinemia and plasmacytosis).

There was no history of heart disease, congenital or rheumatic, in either patient, nor was there prior history of pulmonary disease. Neither gave clinical evidence of repeated embolization, and cases are undoubtedly closely related to those

and amniotic fluid embolism seems unlikely in the two women in view of the stage of the pregnancies at the time of onset of symptoms. Neither patient was shown to have "collagen" disease, polyarteritis, arthritis, Raynaud's phenomena or glomerulonephritis. In each case the vocal cord paralysis was possibly due to pulmonary artery enlargement. Contrarily, the relationship of the nausea and vomiting and associated weight loss was in no way explained anatomically.

Carpenter and Pritchard³ have described cases of primary pulmonary vascular disease in children, and in reviewing 140 papers published between 1900 and 1956, they could not find an authentic case of this disease in a patient beyond the second decade. However, Rawson and Woske⁵ have just recently reported four cases of primary pulmonary hypertension in adults, one of whom was 6½ months pregnant. In their review, they found 39 other cases, most of the victims being female, in a 7:1 ratio.

Etiology Unknown

The etiology of the "syndrome" is unknown, although pulmonary embolic states⁶ and pulmonary vascular shunts have been proposed as the cause of primary pulmonary hypertension. Enough evidence has not accumulated and too few cases have been reported in adults to warrant any positive assignment of etiology to the unusual set of signs described here, but these

with idiopathic primary hypertension of the pulmonary vascular system. The scanty circumstantial evidence (pregnancy) suggests a sensitization phenomenon as a possible underlying cause.

It would seem important for obstetricians in particular to be aware of the unusual symptoms and signs so that the patient with the "syndrome" may be carefully observed and protected during the obstetrical delivery. The occurrence of the death following anesthesia commends the possible role of hyperexcitability of the heart, secondary to "stress" or cyclopropane anesthesia. However, in view of the progressive nature of the disease, and the outcome of Muirhead, Montgomery and Gordon's case, eventual heart failure could have been anticipated had the patient survived the puerperium.

The term "endarteritis obliterans," which is frequently used in description of the histopathology associated with primary pulmonary hypertension, is probably improper since, as Castleman points out,⁸ there is really no evidence of an arteritis. A better term might be obliterative hyperplastic sclerosis of pulmonary arterioles.

Summary

An 18-year-old woman developed progressive dyspnea, left vocal cord paralysis and severe weight loss following persistent nausea and vomiting during the second and third trimesters of her second pregnancy. She died during obstetrical anesthesia and was found at autopsy to have obliterative hyperplastic sclerosis of the

pulmonary arterioles. This is probably another case of "primary pulmonary hypertension," and it is the second of two cases reported in which pregnant women with very similar symptoms and signs prior to death were found to have the same underlying pathologic changes in the lungs.

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Antique Equipment Donated to Restored Pharmacy

A rare collection of eighteenth and nineteenth century pharmacy equipment, glassware and ceramic jars has been presented to the recently restored McDowell Apothecary in Danville, Ky., by Chas. Pfizer & Co., Inc. The 180-piece collection of antiques includes colorful glassware of period design made by early craftsmen in Scotland, England, France and the United States. Among the older pieces are English Delft drug jars dating back to the middle of the eighteenth century, two rare green carboy-shaped stock bottles made in Scotland in about 1780 and a massive leech jar.

The apothecary's shop—honoring Dr. Ephraim McDowell, who performed the first successful oophorectomy—was restored by the Kentucky State Medical Association and the Kentucky Pharmaceutical Association.—*Journal of the American Medical Women's Association*, Vol. 16, No. 2, 1961.

Jimson Weed Poisoning in Children

ROBERT K. GIBSON, M.D.*

Muncie

DATURA STRAMONIUM, known as Jamestown or Jimson weed, stinkweed, thorn-apple and devil's apple, grows abundantly in rural areas of Indiana. The leaves, roots and seeds of this plant contain large amounts of the belladonna alkaloids, atropine and hyoscamine. In the late summer and early fall months the seed pods mature and rupture, making the seeds readily available to children. Acute atropine intoxication, to which children and infants are particularly susceptible, can result from the ingestion of the leaves or seeds of this plant. This type of atropine intoxication is usually more severe than that resulting from overdosage of spasmolytics or from the use of atropine as a mydriatic solution.

Three Case Reports

Three cases of atropine poisoning following the ingestion of Jimson seeds were treated at the James Whitcomb Riley Hospital from 1958 to 1960.

Case 1. A 5-year-old white male was admitted on 10/31/58 for fever and irrational behavior. This child was well until he awakened from his sleep on the night of admission. The parents stated he acted silly, thrashed about, and felt warm to touch. The family physician found an elevated temperature and gave the child a Penicillin injection and aspirin per rectum before referring him for further therapy. En route to

the hospital the patient vomited and had some generalized twitching of the extremities. There was no history of drug ingestion.

Physical examination revealed an irrational child who mumbled incoherently. T 99, P 160, Resp. 30. His face was flushed and he had circumoral pallor. His pupils were widely dilated and fixed, and the optic discs were flat. The remainder of the examination was unremarkable.

Blood count and urinalysis were normal. Cerebral spinal fluid contained 0 leukocytes, 42 erythrocytes, a sugar of 40-50 mgm % and a protein of 9 mgm %.

Therapy consisted of intravenous fluids and aspirin. The child's temperature rose to 102° after admission and remained elevated four hours. The following morning he was more rational, but was still hyperactive. At this time the parents were interviewed again. They stated Jimson weed was growing in their yard and that the child had eaten "grasses" previously. The boy showed continued improvement and was released on 11/3/58.

Case 2. An 8-year-old white female was admitted on 9/20/59 with the complaints of convulsions and delirium. The night before admission she fell asleep while watching television, and on awakening was unable to walk. During the night she became irrational and hyperactive, and fell out of bed about 10 times. Her mother noted that she was very hot. The following morning she was seen by the family physician and hospitalized. Later that day she had a gen-

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eralized seizure and was referred to us. Initially no history of ingested toxin could be elicited, but later the mother produced a seed pod of Jimson weed from her purse stating another daughter had seen the patient eating some of the seeds on the afternoon her illness started.

The child was stuporous, irrational and disoriented. Her vital signs were normal. Her face was very flushed and the pupils widely dilated and fixed. Her lips and mouth were very dry. No other abnormal physical findings were noted.

Urinalysis and blood counts were normal. The cerebrospinal fluid contained 1 leukocyte, 26 erythrocytes and a sugar of 40-50 mgm %.

Treatment consisted of intravenous fluids and sedation. She developed urinary retention for which she was catheterized once. Her temperature rose and remained elevated for eight hours. She was hyperactive for 12 hours. She was released on 9/24/59.

Case 3. A 4-year-old white female was admitted on 9/23/59 with a complaint of Jimson weed poisoning. She had complained of a headache on the afternoon of admission. When she awakened from a nap 30 minutes later, she was very agitated. The mother stated she was "flushed and jumping all over and was very hot." The patient was seen by the family physician who recognized her symptoms as atropine poisoning, and referred her to this hospital. She developed vomiting and delirium on the way to the hospital. The father stated that Jimson weed was growing in their yard.

Physical examination revealed a very agitated incoherent child who appeared acutely ill. T 102, P 180, Resp. 30. There was a generalized flush of the skin, assuming a scarletiform appearance on the abdomen and upper thighs, and circumoral pallor. The pupils were widely dilated and did not react to light. The lips and mouth were parched. No other abnormal physical findings were noted.

Urinalysis and blood counts were normal.

She was treated with sedatives and intravenous fluids. She remained incoherent, delirious and febrile for 12 hours and then improved rapidly.

Discussion

Atropine is an autonomic blocking agent which affects the postganglionic cholinergic nerves. It

acts directly on the effector cells, increasing the threshold to acetylcholine.¹ It is this property of atropine that accounts for its widespread use as a preoperative medication, mydriatic and antispasmodic. In therapeutic doses it has a mild stimulating effect on the central nervous system. With toxic doses central excitation predominates causing restlessness, irritability, disorientation, hallucinations and delirium. Central nervous system depression may follow the excitation phase if very large doses are given.

Atropine is rapidly absorbed from the gastrointestinal tract and mucous membranes, and distributed to all body tissues. Most of the alkaloid is destroyed by enzymatic hydrolysis in the liver. About 13% of the ingested dose is excreted in the urine within 14 hours.¹

As can be seen in the case histories, atropine intoxication produces a rather characteristic illness. Symptoms develop promptly after ingestion of the alkaloid. The parasympathetic blocking action produces dryness of the mouth, making swallowing and talking difficult. Marked mydriasis causes photophobia and blurred vision. The skin becomes hot, dry and flushed, and body temperature rises abruptly, sometimes reaching dangerous levels. Abdominal distention and urinary retention result from smooth muscle inhibition. The pulse becomes weak and the heart rate rapid.

The dangerous symptoms of atropine intoxication result from central nervous system excitation. Early in the illness there is restlessness, confusion and hyperkinesis. Giddiness, muscular incoordination, gait and speech disturbances soon follow. Disorientation, hallucinations, mania and delirium are common. Depression of respiration and circulation occur only in severe intoxication.

Correct Diagnosis from Symptoms

A correct diagnosis of atropine intoxication can usually be made on clinical evidence. The rapid onset, dilated pupils, dryness of the mucous membranes and flushing of the skin help differentiate it from encephalitis and acute exanthemata. The leukocyte count is usually normal, but it may be slightly elevated. If the diagnosis is in doubt, a test dose of 10-30 mgm of methacholine may be given. The usual response of flush, salivation, sweating, lacrimation and increased intestinal activity is blocked by atropine.¹

When the child is seen promptly after inges-

tion of the alkaloid, gastric lavage with an alkaloid antidote such as strong tea, tannin or charcoal should be performed. Potassium permanganate does not destroy atropine.

Morton² has recommended that the parasympathomimetic drug, pilocarpine, be used in the treatment of atropine intoxication. The calculated dose is given every 30 minutes until the mouth is moist. However, pilocarpine and similar drugs have no effect on the central excitation. Since they alleviate only the minor symptoms of toxicity, Joos³ has recommended that they be used sparingly, if at all.

Intermittent small doses of short-acting barbiturates, chloral hydrate, or paraldehyde are effective against the central nervous system symptoms. Large doses should be avoided because of possible depression in the late stages. Efforts to control hyperpyrexia should be made, using the conventional methods of ice bags and sponges. Since vomiting is a common symptom, parenteral fluids should be administered until the patient can tolerate oral feedings. Spontane-

ous recovery is usually complete in 24-48 hours after the onset of symptoms.

Summary

Three cases of acute atropine poisoning resulting from Jimson seed ingestion are reported. The deranged physiology, symptoms, signs, differential diagnosis and treatment of the illness are discussed briefly. Atropine intoxication should be suspected in any child presenting with an acute toxic psychosis, particularly when mydriasis, fever and flushing of the skin are present.

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Simplicity in Medical Writing

There has always been a need for the concise and simply written medical paper. This, however, is not as simple as it seems, because the moment the physician puts pen to paper he is no longer the plain-spoken, kindly practitioner of the art of medicine, but an entirely different person. He becomes ultra-scientific and on occasion may find himself in a miasmatic labyrinth of gobbledygook. Chesterton's advice—"To write simply is the essence of good English"—is easily forgotten.—John J. Rainey: Simplicity in Medical Writing. *J. International College of Surgeons* 27:779, June, 1957. Reprinted in *The Nebraska State Medical Journal*, May, 1961.

Effects of Isoxsuprine Hydrochloride On Blood Sugar Levels

And on Requirement for Insulin or for Tolbutamide In Normal Subjects and in Diabetic Patients

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INCREASED CIRCULATING epinephrine, whether endogenous or administered, causes hyperglycemia, as do other drugs (for example ephedrine) which stimulate adrenergic effector organs.¹ The hyperglycemic effect is very slight with some of these sympathomimetic drugs; norepinephrine, it is said, may be administered to diabetic patients because its hyperglycemia-producing action is weak.²

Recently chemical compounds structurally related to epinephrine have been studied as vasodilators in conditions of peripheral vascular insufficiency. One of these, isoxsuprine hydrochloride** has been described as an effective vasodilator and antispasmodic in the management of vascular disease.³⁻⁸ In animal studies⁹ isoxsuprine at parenteral doses of about 14 times the expected therapeutic range produces a slight temporary hyperglycemia. Lower parenteral doses produce vasodilation but do not alter blood sugar in dogs. By oral administration isoxsuprine does not affect blood sugar in dogs even when, on a body-weight basis, several hundred times clinical dosage is given.

On the basis of the above information, and since in our clinics, isoxsuprine was found to be effective in the treatment of patients with arteriosclerosis obliterans, some of whom were diabetic, we were interested in determining the effects of this drug on blood sugar, and on insulin and tolbutamide requirements in diabetic subjects.

Method

Acute experiments: Two groups of five subjects each were studied. Group A was healthy adults aged 35 to 62 years. Group B was diabetic patients under control with insulin and matched as closely as possible with Group A subjects as to age and sex. The urine of diabetic subjects was free of sugar or acetone bodies. Immediately after a blood sample was taken from the fasting subject in the morning, 10 mg (2 ml) of isoxsuprine hydrochloride† was injected intramuscularly, and two more blood samples were drawn because preliminary experiments had shown that the peak vascular action of the drug is reached within an hour after parenteral administration. The experiment was repeated one week later and the results were averaged for each individual.

Blood sugar was estimated by the Folin-Wu method.

Chronic experiments: Thirty-five controlled

* From the Departments of Experimental Angiology of the Stuyvesant Polyclinic, N. Y.; and the Swedish Hospital, Brooklyn, N. Y.; and the Department of Experimental Therapy, Spring Valley General Hospital, Spring Valley, N. Y.

** 2-(3-phenoxy-2-propylamino)-1-(p-hydroxyphenyl)-1-propanol hydrochloride; Vasodilan®, Mead Johnson & Company.

† Isoxsuprine hydrochloride was used throughout the study, both orally and parenterally, but for convenience "isoxsuprine" will be used to designate the preparations.

BLOOD SUGAR LEVELS OF FASTING NORMAL AND DIABETIC SUBJECTS TREATED WITH ISOXSUPRINE HYDROCHLORIDE

NORMALS						
Patient No.	1	2	3	4	5	
Age/Sex	37/M	40/M	34/F	55/F	62/M	Mean
8:00 A.M.*	118**	124	122	146	110	124
9:00 A.M.	116	126	125	138	120	125
10:00 A.M.	121	120	128	140	118	125

DIABETICS						
Patient No.	1	2	3	4	5	
Age/Sex	36/M	42/M	34/F	55/F	63/M	Mean
8:00 A.M.*	112	84	96	120	130	108
9:00 A.M.	106	92	103	110	122	107
10:00 A.M.	112	88	106	118	129	111

TABLE I

* 10 mg (2 ml) isoxsuprine was injected intramuscularly immediately after obtaining the 8:00 a.m. blood sample from each subject.

** mg. total reducing substance per 100 ml blood (values for individual subjects are means of two determinations one week apart; each value in the "Mean" column is the average of 10 determinations).

diabetic patients aged 25 to 72 years were studied. Sixteen of these were men. Eighteen patients were receiving 20-60 units of insulin daily, and the remaining 17 were maintained with tolbutamide, 1 to 2 tablets (0.5 to 1.0 Gm) per day. Patients were instructed to take one tablet (10 mg) of isoxsuprine three times daily and to maintain the previously prescribed dietary regimen and dosage of insulin or tolbutamide. Urine sugar and acetone levels were to be determined and reported daily (Clinitest method).

Weekly follow-up visits were used for fasting blood sugar determination and physical examination. At these visits, the patients were questioned carefully concerning the occurrence of any unusual symptoms. The chronic study was continued for four weeks in each case.

Results

Acute: As shown in Table I, intramuscular injection of 10 mg isoxsuprine did not affect the blood sugar level in either normal or diabetic fasting subjects, during a period of two hours after administration of the drug.

Chronic: Isoxsuprine had no detectable effect on the insulin or tolbutamide requirement, in the 35 diabetic patients who received 30 mg of isoxsuprine daily for approximately one month.

Three patients occasionally demonstrated glycosuria (maximum 0.5%). These patients were all on tolbutamide therapy and had had sugar in the urine on several occasions before they were selected as subjects in our investigation. The glycosuria therefore is not attributable, in our opinion, to isoxsuprine action. At no time were acetone bodies detected in the urine of any patient.

Average fasting blood sugar levels are presented in Table II. These patients, as indicated by the control values, were well controlled initially. They did not show significant alteration in mean blood sugar levels during the four weeks of isoxsuprine administration.

A 62-year-old man taking 40 units of insulin daily suffered an upper respiratory infection and was placed on a more liberal diet with increased liquids. His urine the next morning showed 2% glycosuria. Increasing the insulin dosage to 50 units prevented further appearance of sugar in the urine. This was the only significant fluctuation in insulin requirement observed in the course of the experiment, and in our opinion was not referable to isoxsuprine action.

Conclusions

On the basis of the reported experiences, we conclude that:

BLOOD SUGAR LEVELS (FASTING) IN DIABETIC SUBJECTS ON ORAL DOSAGE OF 30 MG. ISOXSUPRINE DAILY FOR FOUR WEEKS

NO. OF SUBJECTS	GROUP	MEAN BLOOD SUGAR LEVEL (mg/100 ml.)				
		Before Isoxsuprine	1st Week	2nd Week	3rd Week	4th Week
18	Insulin	121	119	123	124	122
17	Tolbutamide	122	124	126	119	126

TABLE II

1. Intramuscular injection of 10 mg isoxsuprine does not affect the blood sugar level in either normal or controlled diabetic patients.

2. Chronic oral administration of isoxsuprine at recommended dosages has no effect on insulin or tolbutamide requirements of controlled diabetic patients.

3. Isoxsuprine may be administered safely by mouth or intramuscularly, at or near the dosage cited, for the treatment of peripheral vascular disease in controlled diabetic patients, in confidence that no disturbance of carbohydrate metabolism will result and that it will not be necessary to alter the regimen which has been prescribed for the control of diabetes.

Summary

The incidence of peripheral vascular disorders is higher in patients with diabetes mellitus. Therapies used to treat the vascular problems may adversely affect the state of the diabetes in these patients as well as their response to hypoglycemic agents. Epinephrine and some related derivatives will cause hyperglycemia as well as vasodilation. Thus, any chemically related vasodilator should be evaluated regarding its effect on blood sugar in the diabetic patient.

This report summarizes the experiences with a new chemical cousin of epinephrine, isoxsuprine hydrochloride. Its value as a peripheral vasodilator has been demonstrated. Thirty-five diabetic patients with associated peripheral vascular disorders have been given the drug and

serial blood sugars obtained. In none was there evidence of disturbed carbohydrate metabolism nor was it necessary to alter their diabetic hypoglycemic regimen. Isoxsuprine, in recommended doses, was found to be a safe peripheral vasodilator for diabetic patients.

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Treatment of Ringworm of the Scalp With Griseofulvin

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UNTIL TWO YEARS AGO physicians had to rely on topical treatment to rid children of ringworm of the scalp. These included numerous types of fungicidal ointments, lotions and X-ray epilation. The ointments when applied to the scalp were generally ineffective, for they could not penetrate the keratin which contained the fungi.

In December, 1958, Blank¹ reported the first study in the United States of an effective oral medication, griseofulvin, for the treatment of superficial type mycoses. The drug was derived from *Penicillium griseofulvum* in 1939 by Oxford and his associates² and since then has been isolated from other species of *Penicillium*. Gentles³ used it successfully to cure *Trichophyton* and *Microsporum* infections in guinea pigs. The first report of its oral use in the human was by Riehl⁴ before the Austrian Dermatological Society. Since then, numerous reports⁵⁻⁹ have been published showing the effectiveness and wide margin of safety in this drug in the treatment of various superficial type mycoses.

Griseofulvin is fungistatic, not fungicidal, in its action, as shown by the fact that shed keratin contains viable fungi.¹⁰ Griseofulvin has been found to be deposited in the keratinized tissues of the skin, hair and nails. By inhibiting the growth and preventing further invasion of pathogenic dermatophytes, oral griseofulvin treatment leads to the eventual elimination of the

fungus infection. The mechanisms by which the medicine is incorporated into the keratin are yet unknown.¹¹

It appears that griseofulvin exerts its fungistatic effect on the following organisms: *Trichophyton gypseum* (mentagrophytes, rubrum, schoenleini, sulfureum, tonsurans and verrucosum); *Epidermophyton floccosum*; and *Microsporum audouinii*, *canis* (lanosum) and *gypseum*.⁹

Clinical Study

Our study at the Children's Memorial Hospital was limited to the ectothrix type of ringworm infections of the scalp. Previous treatment in many of the patients had been with fungicidal ointments and frequent washing of the scalp. Months and years would go by before two successive negative Wood's light examinations were recorded for these children.

Griseofulvin became available to us in the early months of 1960 and we decided on a specific plan for therapy regardless of weight or size of the child. In each case the scalp was examined with a Wood's light. Cultures were taken from the hairs of all heads that showed the typical green fluorescence. Following this, each child was given griseofulvin tablets, 1 gm orally to be taken every three days. Approximately one-third of the patients used a 4% iodine ointment locally in addition to the griseofulvin. The children were examined under the Wood's light every two weeks.

We gauged the child's improvement mainly

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GRISEOFULVIN AND 4% IODINE OINTMENT

NO. OF CASES	ONSET PRIOR TO TREATMENT	AVERAGES Negative to Wood's Light
10	0-3 months	8 weeks
9	3-6 months	5 weeks
4	2@22 months 2@21 months	5 weeks

Total 23

TABLE I**GRISEOFULVIN ONLY**

NO. OF CASES	ONSET PRIOR TO TREATMENT	AVERAGES Negative to Wood's Light
34	0-3 months	7 weeks
4	3-6 months	5 weeks
3	8 months 9 months 22 months	15 weeks

Total 41

TABLE II

by the Wood's light examination. During the course of treatment the loss of fluorescent hairs was very slow. It was not unusual to see change in color of fluorescence to a dull green, grey or silver. After the first negative examination treatment was continued for another two weeks. If negative at his next visit, he was seen in four weeks; if negative then, the child was discharged from the clinic. All the cases except one remained negative after the first negative Wood's light examination. Of the 64 cases, there was one recurrence, three months after a supposed cure. Again, the child is taking oral griseofulvin.

Results

Tables I and II show the breakdown of our cases with comparisons of times of onset of the disease and clearing of the infection as shown by the Wood's lamp. Table I shows the results obtained in 23 cases treated with griseofulvin orally and 4% iodine ointment locally. Table II lists results of the 41 cases treated orally with griseofulvin.

Discussion

Sixty-four cases of fungous infections of the scalp are reviewed; 56 were male and eight were female children. Their ages ranged from 16 months to 11 years, and the duration of the disease prior to treatment varied from one week to 22 months. All of the untreated cases showed a typical green fluorescence under the Wood's light and/or had positive culture growths on Sabouraud's media. The ectothrix type of infection was present in all patients. Many other patients were treated for tinea capitis but failed to return to the clinic after the first or second

scheduled visit, so are not included in our evaluation.

Local treatment with the iodine ointment offered little help in speeding up the cure rate.

We feel that our dosage schedule was about at a minimum level but quite satisfactory in the rate of cures produced. Friedman and Derbes¹² recently studied different dosage schedules in the treatment of tinea capitis. They found that 21 of 22 patients treated with a single dose of 3 gms given at one time were cured just as rapidly as those that received 1 gm every day, every other day, or every three days.

We experienced no systemic or cutaneous side effects in our 64 cases. Some of the side effects reported have been the following: malaise, headache, mild gastrointestinal disturbances, leukopenia, urticaria and some macular-papular eruptions.¹³ Blank⁷ reported two cases of urticaria in 200 cases treated. No cross-sensitivity to penicillin was noted.

Summary

1. Griseofulvin, one gram every 3 days, was shown to cure 63 cases of tinea capitis in children, ages 16 mos. to 11 years. There was one recurrence after a supposed cure.

2. There were no systemic or undesirable side effects.

3. Oral administration of griseofulvin is the treatment of choice for tinea capitis.

Materials used in this study were supplied by Schering Co., Bloomfield, New Jersey (Fulvicin).

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Banks for Hearing Research

Five "banks" for temporal bones, to further research in loss of hearing, have been established in the last few months by the Deafness Research Foundation. The Temporal Bone Banks, unlike the Eye Banks, are for basic research. The banks are located at Columbia and New York universities in New York City, Johns Hopkins University in Baltimore, the University of Chicago and the University of Michigan, Ann Arbor.—*Journal of the American Medical Women's Association*, Vol. 16, No. 2, 1961.

Retrolental Fibroplasia: A Constant Vigil

The eye of a fetus
develops normally with
an oxygen tension equal
to that on the peak of
Mt. Everest.

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EARLY IN THE SUMMER of 1960 John W. Ferree, M.D., Executive Director of the National Society for the Prevention of Blindness, forwarded a communication to the editors of all medical publications. In it he stated that he had received a number of inquiries regarding the relationship between oxygen therapy for premature infants and retrolental fibroplasia.

Specifically, these inquiries sought information as to when the knowledge became generally available that uncontrolled use of oxygen in treatment of premature infants might result in retrolental fibroplasia. These communications also consistently expressed the opinion that the entire medical profession and all hospital administrators had a duty to institute and persistently follow procedures, in the administration of oxygen to premature infants, that would reduce the likelihood of retrolental fibroplasia.

Accompanying the letter was an annotated bibliography on the relationship of oxygen to retrolental fibroplasia, prepared by the Committee on Retrolental Fibroplasia, headed by V. Everett Kinsey, Ph.D., Detroit, Mich. and including Algernon B. Reese, M.D., New York; Arnall Patz, M.D., Baltimore, Md.; and Jonathan T. Lanman, M.D., New York. The bibliography included some 18 articles pertinent to the problem, dating from July of 1951 to March 1957.

Dr. T. L. Terry¹ is credited with having first appreciated the relationship between prematurity and a fibroplastic overgrowth in the retrolental space. This recognition was in 1942. During

the next eight to nine years many avenues of investigation were explored in an effort to find the culprit. It was first brought to our attention by Dr. Campbell² that intensive oxygen therapy might be a possible cause of retrolental fibroplasia. Investigation by Cross, Evans, Patz and Lanman, as well as others, led to the realization that oxygen was indeed a factor, if not the principal cause, in the production of retrolental fibroplasia.

The American Academy of Ophthalmology and Otolaryngology held a symposium in September, 1954 which crystalized the thinking on retrolental fibroplasia to that date. In an effort to unify the presentation, highlights of the symposium³ will be outlined.

Disease Process

Clinically the disease process appears in the first month after birth of a premature infant, only rarely occurring after the tenth week. The active phase of the disease is characterized initially by vascular narrowing which is transient and is followed by dilation and tortuosity of the retinal vessels. The veins assume three to four times the normal diameter, and in the far periphery, areas of new vascularization are likely to be found. As the disease progresses the vitreous becomes hazy, neovascularization becomes more pronounced and gray areas appear in the retina, principally in the periphery. In more advanced stages fine strands of newly-formed vessels with their supporting tissue extend into the vitreous cavity, with more and more of the retina becoming involved and detached. At this point

the disease has reached its most active stage. Occasionally a massive intraocular hemorrhage will occur at this time.

The active stage is followed by a period of regression, spontaneous in character, which can occur at any stage in the active phase of the disease. Obviously, the earlier in the disease this regression occurs the less severe the damage; the later regression occurs the more extensive will be the destruction. During the active phase there is no way of determining those cases in which the regression will occur spontaneously without serious destruction. The regression phase is followed by a phase of cicatrization. Here, as would be expected, extent of residual destruction varies. In some cases the eye recovers with no clinically visible changes; others show an entire spectrum of residue extending from small retinal scars to the formation of a completely organized retrolental mass.

Findings of Cooperative Study

As a part of the Symposium, V. Everett Kinsey⁴ reported findings of the Cooperative Study of Retrolental Fibroplasia supported by the National Institute of Neurological Diseases and Blindness of the U. S. Public Health Service, National Foundation for Eye Research and the National Society for the Prevention of Blindness as well as the Kresge Eye Institute. The cooperative study involved 18 hospitals located in various cities in the Eastern half of the United States. Period of clinical trial was July 1, 1953 through June 30, 1954.

Premature infants who weighed less than three pounds and five ounces at birth and survived 48 hours were assigned at random to two regimes of oxygen administration. The first group received oxygen for approximately 28 days; oxygen concentration was at least 50%. This was taken as the usual procedure employed at that time. In the second group the oxygen was curtailed and administered, on the counsel of the pediatrician only, in situations of frank medical need. In this study, involving 786 premature infants, it was found that mortality rates in the routine and curtailed oxygen groups did not differ significantly, either during the first three months of the study or throughout the entire year.

Incidence of active retrolental fibroplasia in the oxygen group was approximately twice that in the curtailed group, and the incidence of the

cicatricial grades of the disease in the routine oxygen group was approximately three and one-half times that in the curtailed oxygen group. Incidence of both active and cicatricial retrolental fibroplasia was less for infants of single birth than those of multiple birth. Particularly interesting was the fact that the incidence of both active and cicatricial retrolental fibroplasia increased rapidly with increased duration of exposure to oxygen. Incidence of cicatricial retrolental fibroplasia, for the most part, was not dependent upon the concentration of oxygen administered. Thus, incidence was not appreciably less for those infants of single birth who received concentration of 33%, than for those who received an average concentration of approximately 50% for similar periods of time.

It was felt that for all practical purposes there is no concentration of oxygen in excess of that in air that is not associated with risk of developing retrolental fibroplasia. The recommendation of the Cooperative Study Group was, "The length of time a premature infant, particularly an infant of multiple birth, is kept in an environment containing oxygen concentrations in excess of that of air should be kept at an absolute minimum consistent with the clinical indications of anoxia. When oxygen therapy is clearly required it should be prescribed on an hourly basis in concentration as low as possible."

Severity—Weight Ratio

Studies on experimental animals by Campbell, Ashton and Patz showed that when newborn or young mice, rats and kittens were exposed to high oxygen concentration lesions typical of early retrolental fibroplasia could be produced. It was their feeling that the common factor fundamental to the experiment was that the retina had not completed its vascularization; once the vascularization had been completed the lesion could not be produced. It was felt that the newborn kitten or four-day-old rat retina was vascularized to the same degree as a seven-month fetus. This would explain the inverse ratio of severity of retrolental fibroplasia and the weight of the premature infant.

While widespread acceptance of oxygen as a culprit in the production of retrolental fibroplasia is no doubt valid and must be respected, some disturbing aspects still remain. Ashton⁵ and his associates hypothesized that the closure of the

retinal arterioles might be due to external pressure from fluid imbibition by the retina as a result of interruption in glycolysis. They therefore investigated the action of sodium fluoride and sodium iodoacetate, both glycolytic inhibitors. These substances caused total obliteration of the retinal vessels of the kittens similar to that produced by exposure to oxygen. This did not occur in the retina of the adult cat. The vessels reopened when the retina became detached from the choroid. Whether the mechanism of oxygen vaso-obliteration is related to these findings is certainly not known. Fortier⁶ noted that during the late 20's and most of the 30's practically all oxygen was administered to premature infants as a mixture with 5% to 10% carbon dioxide. It was his feeling that only as the swing toward pure oxygen was accomplished was retrolental fibroplasia to become a clinical problem.

Reduced Interest Follows Control

Zacharias,⁷ commented on the noticeable reduction in the interest and investigation of retrolental fibroplasia in recent years as a result of the marked reduction in its frequency following more controlled oxygen management. At the Boston Lying-in Hospital she has found fewer babies requiring supplementary oxygen and for shorter periods. In 1954 for example, 88% of the infants under four pounds were given supplementary oxygen; by 1958 only 48% received this treatment. In 1954 the average number of hours was 92 per infant and in 1958 it had been reduced to 15. This has resulted in a significant reduction of mild retrolental fibroplasia as well as the cicatricial form.

She observed it was not possible to know whether the maximum reduction of oxygen therapy had been reached, but assumed that there would be a percentage of infants who would continue to need oxygen for survival. Of particular interest was the fact that they had found in the past few years several cases of retrolental fibroplasia in infants who, insofar as they had been able to learn from a thorough check of the hospital records, had received no supplementary oxygen. Five such infants developed mild retrolental fibroplasia; one suffered severe change. Two infants showed retrolental fibroplasia after only 11 hours in oxygen and one severe case developed in an infant who received supplementary oxygen for only seven hours.

These occasional cases in infants who received little or no oxygen suggest that there is some other causative mechanism. Chisholm⁸ recently expressed a similar sentiment, stating that the control of oxygen has resulted in a marked reduction in incidence and interest; however, as the true etiology is unknown, sporadic cases without oxygen or in term babies still appear.

Summary

A review of the pertinent literature was presented in an effort to maintain awareness and caution in the management of the premature infant. The most widely accepted management is based on recommendations of the Cooperative Study by V. E. Kinsey and others. The author's recommendations: "The length of time a premature infant, particularly an infant of multiple birth, is kept in an environment containing oxygen concentration in excess of that of air should be kept to an absolute minimum consistent with the clinical indication of anoxia. When oxygen therapy is clearly required it should be prescribed on an hourly basis and the concentration should be as low as possible."

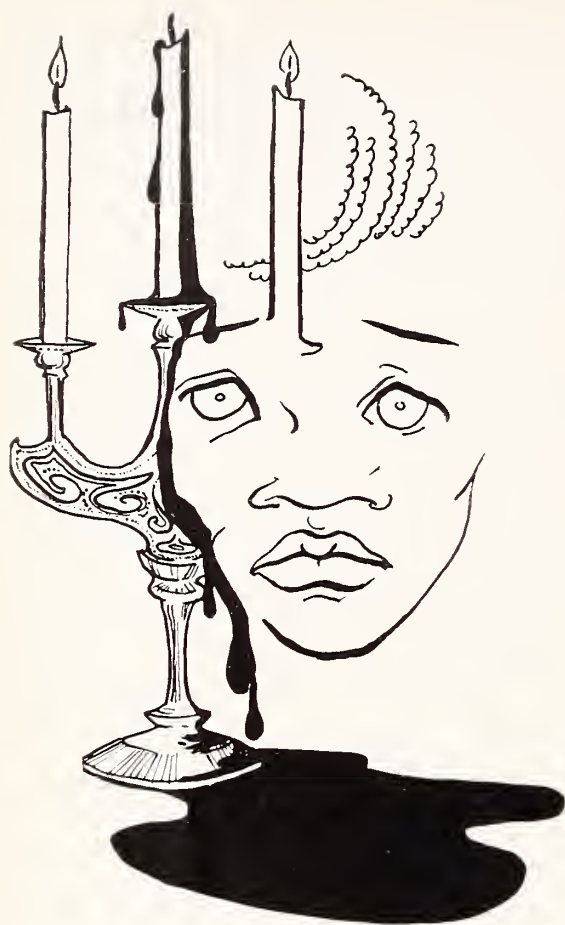
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The Case of Sacerdotal Confusion

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SACERDOS being the Latin word for priest, it is obvious that anything sacerdotal must pertain to the priesthood. In addition, there is the theological doctrine that asserts existence of a divine grace mantling the very act of ordination. An extension, *sacerdotalism*, is the famous claim made by the Vatican Council as late as 1870, namely, that when speaking *ex cathedra* on matters of faith and morals, the Roman Pontiff "possesses, by the Divine assistance which was promised him in the person of the blessed Saint Peter, . . . Infallibility."

Relevant also to what follows is existence of numerous Protestant splinter sects. Especially among North American Negroes and Indians, there are many nominally Christian groups that continue practices carried over from pagan days. A very odd group of dissenters from Baptistry call themselves members of "The Church of Moses the Redeemer."

All this is preliminary to the tale of Bessie Black; her story makes a coherent whole only

when presented chronologically. In the early thirties, close personal friends of mine built a new house a few doors from my home. The very day they moved in, the lady of the family called me, "Arnold! The neighborhood house has just sent me a new girl; she does not look like much but I'm desperate for just anybody. Please, let me bring her down and make sure she has nothing contagious; it shouldn't take more than a few minutes."

Fum Sunflowah, Mississippi

When shepherded to the examining room, Bessie Black announced herself as follows, "Ah's fum Sunflowah, Mississippi. Ah's a house nigguh and not a trashy field hand."

Much less than five feet in height, she was squat and scrawny, even if well muscled. Clad in the most outrageous nightmare of castoffs, she was fidgeting uncertainly and was obviously ill-at-ease. Across her face, extending diagonally upwards from the left angle of the jaw to the

right temple and just missing the right orbit, there was the hideous keloid of a scar. "De Massa Paul dun whup me," she explained when asked. Her eyes were large, luminous, alert and quite intelligent even as they roamed about restlessly while their owner was appraising her new, strange and, possibly, hostile environment.

Bessie gave her age as "abht 16"; she had spent the last seven years working on the same plantation. Her parents she did not remember; she had gone to school parts of two winters. Her "big sistuh" had gone North because "her man" had gotten the promise of a well-paying job from some labor recruiter. Bessie seems to have just tagged along. She was not exactly articulate and her weird, back-woods dialect made communication really a problem.

Bessie's somewhat kinky hair was as clean as was her body; when she opened her thick lips, the teeth were gleaming white. Her vision and hearing were excellent; the heart and lungs were fine; there were no contagious diseases—all reflexes and the ordinary laboratory tests were within normal limits. All her belongings were in the small cardboard box that she carried in lieu of a valise.

That very afternoon, Bessie was installed in our block; within the week, all the households on the block knew her. In a few weeks, she was on the road to becoming a neighborhood fixture. She was a glutton for work and possessed an uncanny knack for getting along with children—maybe because her thinking was on their pre-kindergarten level.

The years skipped along as they have a habit of doing; Bessie was solidly entrenched as the nursemaid and general factotum of several adjoining households, mine included. She was taught to read a bit and even acquired some ability to write. I was told that she was a very religious person; however, she went to church on Saturdays, not Sundays.

Infallible Predictions Through Dreams

My wife told me that Bessie belonged to some heathenish Baptist sect that professed Christianity but practiced many rites smacking of voodooism. Bessie's sister had taken her to this outfit that rented an otherwise empty store in the poorest section of town. Also, albeit dimly, I was made aware of the fact that Bessie perused the Bible most assiduously. In addition, Bessie became almost notorious for being an implicit

believer in dreams and their interpretation: she had the certitude that proper understanding could predict most infallibly the future . . . other things.

All this being none of my concern, I paid but scant heed. Her mistress related to me that Bessie would tell of "dreams" which she would proceed to embroider, slant—and eventually insist that events had transpired as she had predicted. One day, a three-year-old toddler in our block had started to go out into the street following his little puppy. Bessie had dashed out and grabbed him back to safety even as a passing motorist had failed to stop for the straying dog. The poor thing was run over and killed instantly. Later, Bessie told me that she had had one of her "dreams" that morning; it had warned her to watch the actions of the youngster; she had been on the look-out; this had enabled her to be on the scene in time and so avert the very real danger to the boy even if she had not been quite quick enough to save the puppy.

Making conversation with an innocent comment, I told Bessie that she had been a regular Joan of Arc who also had been guided by her voices. Of course, Bessie had never heard of the Maid of Orleans; she asked; I explained briefly. Afterwards, I learned that her mistress has been asked by Bessie to get her something to read about Joan. One of the Catholic ladies on the block also gave Bessie a profusely illustrated brochure on the same topic; the church used it in its missionary work. Little did the worthy ladies and I dream of the dragon teeth that we were sowing; it was just as well that we were blissfully unaware of the paths over which Bessie was to wander.



Bessie Goes Courting

A whole decade passed by in this fashion. Suddenly our block was titillated by the news that a certain plumber was courting Bessie. He was a widower in his forties; he had an establishment not far from her church. He seemed to be a rather pleasant, intelligent chap; he was childless and he needed someone to take care of him and also to supervise his shop. After a brief interlude, Bessie accepted him and left our block.

She was missed most genuinely by all the grown-ups and wailingly so by the toddlers and even older children who found it difficult to understand her absence. No longer was she there to guide them across the street to the school, to pull their sleds in the wintertime and to help them roller skate in the summer. However, my two girls had developed rheumatic fever and I had moved West; World War II came along. We lost touch with Bessie Black.

More years passed by; the War ended; on one



of my visits back to the old home town, Bessie's husband sought me out for a very private conversation. Could I take the time to visit the minister of Bessie's church? Why? Well, would I please? I did.

On the entrance door was the boldly lettered inscription, "Church of Moses the Redeemer." To one side of the threshold was a cubicle in which I found ensconced the gentleman in question. In the several preceding years I had on numerous occasions visited the Apache reservation; still, it was a bit startling to find one in a Chicago suburb. Clerical garb covered only very superficially the tough Geronimo brave glaring his implacable hatred at the white intruder. He almost sneered as I introduced myself and made a tentative opening gambit by expressing my mild conversational surprise at the name, Moses, being used by a group professing to be—basically—Christian. "Well, you white Jews have no monopoly on him. If you look in the Book of Numbers, chapter 12, verse 1, you will observe that Moses married Zipporah, the Cushite. Of course, this tribe was Ethiopian, i.e., Negro."

He paused and leered at me for dramatic effect. "Is that why so many of your women are named after Miriam, his sister, and none after the black wife?"

"All that may be true but I came at the request of Bessie's husband; he seems bothered by her behavior."

Loyal Helpful Member

"Oh, that man is just another Uncle Tom but she is a loyal member and helps set up the space in back of the altar every Saturday night. That is where I commune with Moses before my 8 p.m. service."

This last statement he actually flaunted in my face. Mayhap, he was expecting slyly the inane retort as to whether the time changed with daylight saving. I restrained that impulse and came to the point directly, "Do you use pure mescal or the usual peyote? Do you ever give Bessie any?"*

* The literature on the ceremonial use of hallucinogenic agents is very vast indeed. Any good text on pharmacology is informative. There are exotic monographs such as *Mushrooms, Russia and History* by Valentina-Pavlovna Wasson and her husband, R. Gordon Wasson; Pantheon Books, 1957, \$125.00. The N. Y. Botanical Gardens have this volume in their library. A sociological text helps elucidate the meaning of "trances" within the context of that particular individual's cultural background. 25¢ enables one to invest in Ruth Benedict's *Patterns of Culture*; Pelican Books—a classic.

It was the cleric's turn to be surprised; the detested white man was not supposed to be acquainted with Indian customs. My mild and meek tone diminished his truculence. He was almost defensive as he attempted to extract the verbal barb with, "Oh, no. That is hardly ever necessary for me. My grandmother was a Shasta Indian shaman who could go into a trance almost at will. I've inherited this ability. I cannot guarantee being able to hear Moses always—but, in a proper setting, it is almost a certainty. And as to giving Bessie anything at all: why should I?" This was said with emphasis.

The man had read widely and was well-versed in his field. We detoured into a rather interesting discussion. I quoted *Modern Clinical Psychiatry* by Noyes & Kolb as to the meaning of delusions (5th ed., p. 104-6); also, I dragged in Ruth Benedict, the sociologist, in summarizing her classic work in the *Patterns of Culture*, already alluded to. He countered by taking down his volume on *The Encyclopedia of Occultism*. Later, I saw an ad for this item in the staid *N. Y. Times*: Mystic Arts Society, New Hyde Park, N. Y., \$15.00. Anyway, the villain was almost friendly by the time I left his "church."

Preacher Causes Financial Drain

I hied me directly to Bessie's home and proceeded to have a real huddle with the two of them. The husband was worried by the financial drain being caused by the preacher. The seances with Moses frequently led to directions for larger donations to the church. Also, Bessie's dreams were becoming more regular and vivid. She never claimed to have seen anyone; always, it was angel voices speaking to her. Just that very last Sunday, Bessie asserted that Jesus himself had spoken to her!

Bessie took down a well-thumbed, illustrated booklet on *Joan of Arc*; it told simply and well the standard version of the life and martyrdom of the Maid of Orleans. Groping earnestly, Bessie recalled to me that it was I who had first compared her dreams to those experienced by St. Joan; it was her mistress who had read to her much of the material relating to the maid; that it was a pious Catholic lady of our block who had given her the very booklet she was displaying to me.

All this was more than a little distressing to me. How was I to explain to Bessie that the cult of the peyote plant is acceptable among some

Western Indians but not—emphatically not—in prosaic mid-20th century Chicago. How was I to make intelligible to her the sober, stark fact that a trance is just not acceptable socially within the pattern of Chicago life. In our society today such "dreams" are stigmatized as being either quackery or prima facie evidence of insanity.

Could I confuse the poor woman still more by introducing her to Don Quixote, that poignant and fabulous legend of the gentle Knight (practicing all too perfectly) noble aspirations—alas, several centuries too late and so left out of context—unsupported by the normal, accepted standards of his contemporaries. It was bad enough for me to feel the guilty burden of having introduced Bessie Black to the story of Joan of Arc. . . .

As an adolescent, Bessie had accepted voodooism as entirely normal. That was a bad start for anyone; now, as an adult, she had the incredibly bad luck of being continuously indoctrinated by a "clergyman" who was in actual fact a shaman to whom delusions were a natural experience. How, in the Name of Heaven, could I make clear to her that her religious aberrations (within the pattern of Chicago culture) would be taken as irrefutable proof of lunacy.

Picking my words with utmost circumspection, I pointed out to Bessie that Joan of Arc had lived five centuries and more before our time. In those days, Catholicism made the ecstatic experience a mark of sainthood; present day Church doctrine was in clear opposition to the things Bessie was doing. I also went further and said that, while the shepherd of the flock at the "Church of Moses the Redeemer" just might be a really honest person, he did hate violently the white man who had wronged his people. Now, Bessie certainly did not hate the people she had known in our block, did she? I did not dare refer her to any books on medieval beliefs. I would, however, mention to anyone tending to feel superior to the benighted heathen such curious even if biased treatises as, say, the one by Jules Michelet, *Satanism and Witchcraft*, Citadel Press, 222 Fourth Ave., NYC 3, N. Y., 1939. It might be a bit jaundiced but the bibliography is unrivaled.

Brainwashed All Too Well

Would Bessie object to having the minister of the regular Baptist church visit her? No!

She would not! And, if I asked her as a favor to me, would she mind having a priest from the local Catholic diocese present to her the full story of Joan of Arc? Would she listen faithfully? She certainly would! Bessie assented readily but I left feeling that she had already been brain-washed all too well; she was a Pavlov dog with conditioned reflexes which would not erase. . . .

Several more years passed; for a variety of reasons, I had not been near my old home town. And then I got a most incoherent scrawl from the Westville Hospital; in essence, Bessie was locked up and was pleading for release. I was shocked but not too surprised. I contacted Bessie's former mistress who gave me much detailed information. The hospital superintendent was most courteous; my telegram drew a prompt and illuminating response. The doctor in the home town knew all about the matter also.

Stripped of verbiage, the progression of Bessie Black's delusions was unequivocally clear. The cult of "Moses the Redeemer" dominated her life. In mimicry of the shaman preacher, she developed the obstinate obsession that, every Sunday morning, at 9 a.m., she could enter into conversation with the Lord Jesus Himself. . . . Finally (so the husband's uncontradicted sworn statement went on), one evening, Bessie had taken from the shop two huge Stillson wrenches; these she laid by her side in bed. True, there had been a hold-up in the alley at the back of the shop; Bessie had seen it and had been terribly frightened; she stated that she was taking them to bed with her for self-protection. Nevertheless, the harried husband was fearful lest Bessie might flail out with those lethal weapons at the behest of her "voices"; he was afraid for his life; he requested a psychiatric examination of Bessie.

The family physician came and talked with her; under some thin pretext she was inveigled to the Central Police Station. There, two more good physicians went over her; a consultant in psychiatry interviewed her several times. Joe Jenks, the chief of detectives and an old playmate of mine, was meticulous in his description of what went on. Bessie was given every possible break; prominent and sympathetic citizens attempted to aid her; there was a whole series of conferences. Unfortunately, Bessie was transparently truthful in her guileless confirmation of her husband's statements: the facts (and the

conclusions to be drawn therefrom) were not to be gainsaid!

No Choice But Commitment

The medical board had no choice but to recommend commitment; the legal lights concurred; and there she was. The subtler aspects of the theological problems (as I saw them) gave a very different interpretation to poor Bessie Black's dilemma. However, what right did I, a mere internist, have to tell my learned colleagues that they should read up on sociology? How was I to convince them that what is rational in the context of one civilization—that same thing may be totally inadmissible and completely psychotic in the context of the mores of another culture?

Was I to illustrate my point by calling the attention of the splendid board men in psychiatry to a new 1960 stamp issued by the Dutch? Johannes Wier was a Dutch physician of the 16th century; this stamp commemorates his revolutionary contributions. His most famous book bears the intriguing title, *On Demonic Bewitchment, Conjuraton, Exorcising and Poisoning*. . . . Would any sane doctor today send such a title to a scientific journal of any repute? Obviously, I did *not* mail these stamps to anyone. I did have an illuminating talk with my old friend, Joe Jenks; I contacted the committing judge and doctors; I succeeded in getting Bessie paroled to the care of her husband. She was forbidden all further contact with that "minister" shaman from the "Church of Moses the Redeemer." Further, I was helpless.

SO: When is Don Quixote a paragon of all the virtues and when is he a ridiculous lunatic simpleton? How to differentiate the quixotism of Bessie Black from dangerous insanity? When is SACERDOTAL CONFUSION transformed into a psychiatric phantasm? How easy is it to commit a normal person? The answer evaded me even if the question recurred. Was any unequivocal judgment possible?

My point would have been made could I have said basta, enough, right there. But (with a bow to the late senator from Wisconsin): "There is a letter in my hand . . ."

Violates Her Parole

It is from my old grammar school chum, Joe Jenks, the taciturn foil to my gabby garrulity. "Last Saturday night"—the letter reads—"Bessie Black had violated her parole and gone to

help her minister with his preservice communion with Moses. Almost an hour later, the janitor walked into the chapel and found the preacher stretched on the floor: dead. Bessie Black was sprawled insensible on a couch. The heavy brass candelabra was clutched tightly in her large, muscular fist. Medical examination proved that both had imbibed large doses of peyote. The woman was revived with difficulty. She remembered nothing after the time when the minister had given her some tea. The back of the man's skull had been struck a severe blow; it was hard to tell whether this was from a fall or whether from a blow by the wielder of the candlestick: there were some hairs matching the preacher's adhering to the side of the candelabra. . . ."

Joe Jenks continued his terse summary, "The

police believe Bessie Black when she says that she blanked out and when she states that she did not know that the tea was doped. There was no publicity; the preacher had a sedate, Christian burial. However, Bessie Black is being recommitted to the state hospital for further treatment. The technical charge against her is violation of parole in having gone to see her minister. . . ."

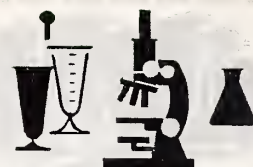
Not long ago, my wife and daughters had asked me, "But, daddy! How can you be *sure* that Bessie is safe and sane?" I am not going to say anything more on this subject to anybody. Basta, enough. Even a stubborn old man ought to be convinced by the obvious. . . .

1270 Fifth Avenue
New York, 29, N. Y.

Staphylococcal Food Poisoning

Staphylococcal food poisoning is overwhelmingly the most prevalent of food-borne infections in the United States. . . . 95 outbreaks of staphylococcal food poisoning in 1955 and 1956, reported in the weekly communicable disease summaries issued by the Public Health Service, were surveyed. . . . In 94 out of 95 outbreaks, the vehicle of this disease was reported as cooked food, which contained large proportions of protein. . . . In 63 outbreaks, or 67%, the vehicles were food mixture such as tuna salad, turkey salad, creamed chicken, potato salad, meat loaf, chicken pie, egg salad, and cream-filled pastries. Such mixtures are usually handled extensively after cooking. . . . Leftover food was the reported vehicle of this disease in 94% of 86 outbreaks reporting this information. Unrefrigerated food was reported as the vehicle in 74 of 83 outbreaks supplying information on manner of handling food after cooking. . . .

Contrary to currently accepted theory, it is clear that outbreaks commonly occur when the food is handled cleanly by personnel who are free of infections. The widespread presence of pathogenic staphylococci among healthy persons insures widespread contamination of food regardless of care in handling. Therefore recommendations for control of this disease have one objective: to prevent the staphylococci present in cooked protein food from forming enterotoxin. In the absence of precise knowledge, the following standards were arbitrarily chosen to protect food: 40F as the maximum temperature for keeping cold, cooked protein food; 140F as the minimum temperature for keeping hot, cooked protein food; 3 hours as the maximum length of time cooked protein food should be kept between 40 and 140F.—B. E. Hodge, M.D.: Control of Staphylococcal Food Poisoning. *Public Health Reports*, April 1960. Reprinted in the *JAMA*, Vol. 173, No. 10.



Getting the Most from Peripheral Blood Smears

EXAMINATION OF A BLOOD SMEAR as a part of the so-called complete blood count (a misnomer dating back to the infancy of hematology) is one of the most frequently performed laboratory examinations. Performed carelessly or examined by an inexperienced technician or physician, it is often of little value and may be seriously misleading. Properly prepared and interpreted with full knowledge of clinical data, it is probably the most informative of any single laboratory procedure.

It can be used—beyond the routine “differential count”—to check accuracy of hemoglobin determination in conjunction with red cell count, may offer clues as to the cause of the anemia, and may be used as a guide for necessity of further tests. Disturbed rouleaux formation, for instance, best observed in a wet, unstained drop of blood, may be regarded as a presumptive evidence of hemolytic anemia. With an increasing number of potentially hemotoxic drugs, changing patterns of leukemia and better recognition of virus diseases, more and more “atypical” forms of leukocytes are being encountered in daily practice.

Recognizing Atypical Lymphocytes

Occasional atypical lymphocytes may be present in normal persons and as a reaction to stress stimuli, particularly in hypofunction of adrenal cortex. Atypical lymphocytes of the type occurring in virus diseases and now designated as “virocytes” can be recognized in smears by experienced observers. Small immature cells of “blast” type (micromyeloblasts) are too often reported by inexperienced technicians as atypical lymphocytes and the diagnosis of acute leukemia thus missed.

By means of rather simple cytochemical stains, significant information regarding the functional activity of the blood cells can be easily obtained.

(a) Alkaline phosphatase stain is of value in the differential diagnosis of various forms of polycythemia and in distinguishing leukemia from leukemoid reaction. In normal persons, most of the neutrophils reveal no or little alkaline phosphatase activity. Activity is *increased* in infection, leukemoid reaction, polycythemia vera and myelofibrosis; it is markedly *decreased* in chronic granulocytic leukemia.

(b) Heinz body stain is of value in patients with hemolytic anemia caused by toxic agents.

(c) Prussian blue reaction for iron is of value in demonstrating so-called siderocytes (erythrocytes containing iron granules) in unusual cases of anemia and in bone marrow smears for evaluation of non-hemoglobin iron storage.

(d) Recently, two stains have been described for differentiation of red blood cells containing fetal (F) or adult hemoglobin (A or S).

Case Report

A few illustrative cases follow as examples:

Case 1. A 64-year-old male was found to have a normocytic anemia with hemoglobin of 9.4 gms and red blood count of 3,200,000. Blood smear revealed a mild anisocytosis and 2-3 normoblasts per 100 leukocytes. The differential count was not unusual; reticulocyte count: 0.4%; total serum bilirubin: 0.9 mg; and bone marrow examination revealed a cellular marrow containing small clumps of neoplastic cells. Acid phosphatase was 3.4 Bodansky units (normal: 0-1) and needle biopsy of prostate established the diagnosis of invasive carcinoma of prostate.

Presence of normoblasts in peripheral blood smears of adults should arouse suspicions of a bone marrow replacing process, such as metastatic carcinoma, leukemia, myelofibrosis or a severe hemolytic anemia if associated with reticulocytosis. In an elderly male, the first consideration would be metastatic carcinoma, possibly of prostatic origin.

Case 2. A 45-year-old male consulted a physician because of fever, aching and general malaise of two weeks' duration. He was treated with antibiotics without any improvement. The white blood count was 7,800 and the differential count was reported as showing 74% lymphocytes. A review of the blood smear revealed the predominant cell to be a small cell with immature nuclei interpreted as micromyeloblasts. Accordingly, a diagnosis of acute leukemia was made and confirmed by a bone marrow examination.

Case 3. A 6-year-old white girl was hospitalized because of severe anemia. Hemoglobin was 5.4 gms, red blood count: 3,100,000; white blood count: 10,800. The blood smear revealed a marked hypochromia with microcytosis and poikilocytosis, many normoblasts, occasional

Howell-Jolly bodies and numerous thin erythrocytes, designated as leptocytes and target cells. These findings suggested a severe hemolytic anemia of "thalassemia major" type and electrophoretic study established the diagnosis of thalassemia-Hemoglobin C disease.

Conclusion

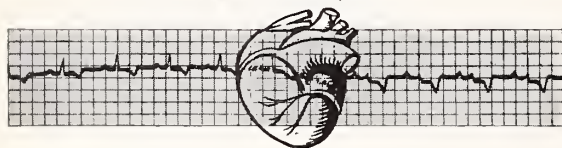
Careful examination of a well-prepared blood smear with proper attention to details of technic, interpretation of cells and clinical correlation is extremely rewarding and may rapidly establish diagnosis or a clue to it with minimum cost. ◀

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New Pathology Forum

The Pathology Information Committee of the Indiana Association of Pathologists will conduct a "question and answer" column in the Pathfinder section of The Journal. Queries in the fields of anatomic or clinical pathology may be addressed to The Journal, 1019 Hume Mansur Bldg., Indianapolis 4. Answers and discussions will be published periodically.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Myocardial Infarction

CHARLES FISCH, M.D.*

Indianapolis

THE PATIENT, a 99-year-old female, was admitted to the Marion County General Hospital Feb. 19, 1961, with a history of bronchial asthma of many years' duration but without any acute episodes during the past three years. The reason for her admission was a sudden onset of rather severe nocturnal dyspnea. Examination revealed a cooperative, orientated lady in acute respiratory distress. The pulse was 84, respiration 36 and blood pressure 185/110. There were moist rales throughout the chest. The heart was enlarged to the left with a harsh grade II systolic murmur at the apex, poorly transmitted. The remainder of the examination was of no consequence. She was treated with bed rest, digitalis, diuretics with some improvement. On Feb. 26, 1961, however, she complained of substernal pain and recurrence of dyspnea. The symptoms became progressively more severe and the patient expired Feb. 28, 1961.

Postmortem examination disclosed a myocardial infarct, measuring about 3 centimeters in diameter, located in the posterolateral wall. The pathologists felt that the infarct was approximately one week old.

* From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association, Indiana State Board of Health and the National Heart Institute (H.T.S. 5363).

Cardiogram Analyses

Analysis of the electrocardiograms shows that on Feb. 21, 1961, the patient had a normal sinus rhythm with the only significant abnormality being depression of the ST segment in Leads V-5 and V-6 with a terminally upright T wave. There was no essential change in the tracing on Feb. 22, 1961. Small Q waves in leads III and AVF are of questionable significance. A repeat tracing taken Feb. 27, 1961, shows no change in the initial portion of the QRS complex; however, there is a decided widening of the ventricular complex, the QRS measuring approximately .11 seconds with what appears to be primarily a delay of the middle and terminal portions of the QRS complex. The ST segments in V-5 and V-6 are again depressed with terminally upright T waves.

These tracings are interesting in view of the fact that the patient had a large posterior infarct, yet the classical Q waves did not become manifest at any time. This can be accounted for simply by the fact that the posterior location of the infarction did not disturb the forces in the frontal plane nor reverse the vector in the horizontal plane. However, changes which have received little or no attention in the past, namely slurring, widening and changing contour of the middle and terminal portions of QRS complex did become manifest in our case. This coupled

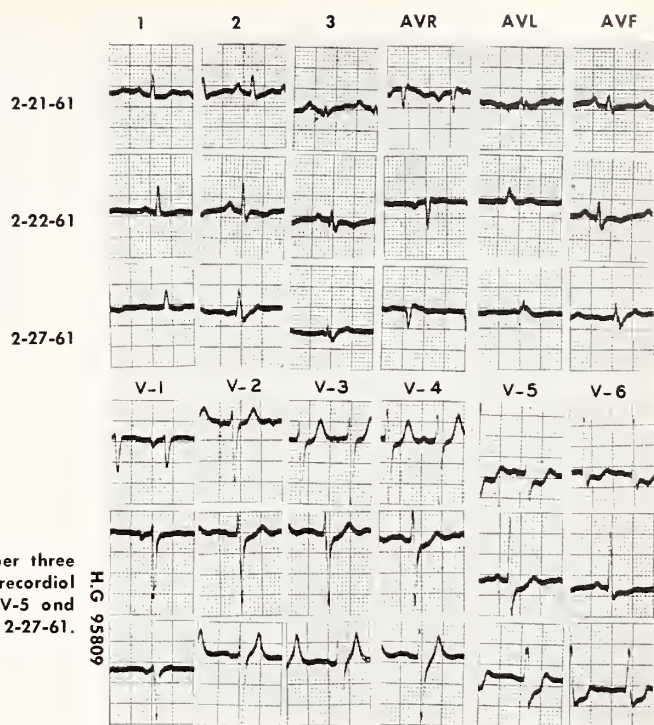


FIGURE 1

The figure represents serial tracings with the upper three rows representing the limb leads and lower the precordial leads. Note the depression of ST segments in V-4, V-5 and V-6, with prolongation and slurring of QRS on 2-27-61.

with depression of ST segments would lead one to the conclusions that: (1) The lesion is in an area opposite to that of the exploring electrode (V5-V6) and this could be either subendocardial involvement of the anterior wall or transmural infarction of the posterior wall, and (2) that the

disturbance of intraventricular conduction is indicative of myocardial damage.

It has become obvious in recent years that a careful study of the "minor slurs" of the QRS complex is necessary and that such an investigation will be made possible with high fidelity and high speed recording apparatus. ◀

LABORATORY MEDICINE

Published periodically as a review
of clinical laboratory procedures
suitable for laboratories with min-
imal equipment.

Osmotic Fragility of the Red Cells

A. WENDELL MUSSER, M.D.*
Indianapolis

THE OSMOTIC EFFECT of hypotonic saline solutions causes normal red cells to absorb fluid thus increasing their volume. Eventually the red cells will rupture and hemolysis will occur. Susceptibility of the red blood cell to rupture when placed in hypotonic saline solution is determined primarily by the ratio of cell size to surface area. Cells which have greater volume and the tendency to be spherical cannot expand as readily in hypotonic saline solution. The classic spherocyte has the smallest possible surface area, and therefore, rupture will occur as the contents of this cell are increased.

Conversely the large flat cell of thalassemia or the flattened sickle cell of sickle cell anemia have an increased surface area relative to the cell size. More water may be absorbed into these cells without resulting rupture. These cells are said to be more resistant to hypotonic solutions than normal cells.

Indications for Testing

The fragility test is a fairly time consuming procedure which is not indicated unless hemolytic jaundice is suspected. Indications for ordering the test are unexplained jaundice of a hemolytic type, abnormal red cell regeneration and splenomegaly. The qualitative screening test will be described here.

* From the Clinical Laboratory, Indiana University Medical Center.

Method

Eighteen small test tubes are set up in a rack and numbered from left to right, 48, 46, 44, through 14. Into the first tube is measured 4.8 ml of the 0.75% sodium chloride solution, into the second, 4.6 ml, and so on in amounts corresponding to the numbers of the tubes. To each tube there is added the amount of distilled water required to bring the total in each tube to 5 ml. The concentration of sodium chloride in each tube will be, from left to right, 0.72%, 0.69, 0.66—0.21. The concentration of sodium chloride may be calculated by multiplying the number on each tube by 1.5 and setting off two decimal places.

Five ml of venous blood is collected with a dry syringe and needle and mixed in a bottle with 7.5 mg of heparin. The blood is mixed and aerated well before use. Exactly 0.2 ml of blood is measured into each tube, and the tubes are gently shaken to insure mixing. A control series of tubes must also be set up using normal blood. The racks containing the tubes are then placed in a refrigerator at 4°C for two or three hours.

The tubes are examined and the point at which hemolysis begins and that at which it is complete are recorded. The slightest trace of red color in the supernatant fluid indicates destruction of the least resistant cells. Complete hemolysis is

indicated by a clear red solution and the absence of a residue in the bottom of the tube or of any cloudiness on gently shaking the tube. The tubes are then incubated for 24 hours at 37°C and re-examined.

Results		
	Slight	Complete
Normal	hemolysis	hemolysis
Normal blood	0.45—0.39%	0.33—3.30%

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**DON'T DELAY IN
MAKING RESERVATIONS . . .**

112th Annual Convention

**INDIANA STATE
MEDICAL ASSOCIATION**

October 24-26

**Murat Temple
Indianapolis**

These dates are somewhat in conflict with meeting dates of the Indiana State Teachers' Association. All members are urged to make hotel reservations early in order to avoid a shortage of hotel space.

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Ninth District Poll Favors Conservatism

CONGRESSMAN EARL WILSON of the Ninth Indiana District conducted a public opinion poll in his district with the assistance of 19 newspapers—4,204 people answered the questionnaire, a huge majority of whom were in favor of the conservative approach to government.

There were 2,722 declaring themselves as opposed to medical care through Social Security; only 782 voted for it. When asked whether they were in favor of such a program being compulsory or voluntary in the event that it was passed, 2,881 felt it should be voluntary if passed; only 446 thought it should be compulsory.

In reply to Representative Wilson's question about federal aid to education, 2,639 were against, 633 for; 601 people were in favor of federal aid to schools for construction (2,027 against); 314 were for federal aid to schools for teachers' salaries and 2,352 against.

Favoring raised postal rates to meet postal deficits were 2,033 persons; 1,360 wanted rates left as they are. Many of those in the "rates as

they are" category wrote letters suggesting that rates for "junk mail" be raised.

The question, "Do you believe the federal government should live within its budget, pay on the national debt when possible, and thereby hold down inflation and restore the value of the dollar?" drew 3,300 yeses and only 158 noes.

The question, "Are you in favor of an agricultural program that will gradually reduce the government's role in farming, thereby getting the government out of farming and aiding in the solution of the farm problem?" was answered by 3,293 people with yes, 158 with no.

A by-product of the survey was a large collection of write-in requests for more such questionnaires in the future.

Representative Wilson interpreted the results of his study as indicating a ground swell for conservative thinking in his district. He also expressed the opinion that his 14-county district composed of industrial, rural and combined rural-industrial areas is a good cross-section of the Middle West.

Political Emphasis Stimulates Cleric's Sermon

POLITICAL ACTION by the National Council of the Churches of Christ, in favor of the Social Security approach to medical care for the aged, has resulted in a variety of disclamations by individual congregations.

Recently the *Indianapolis Star* published the full text of a sermon by Rev. Paul Dewitt Urbano, All Saints' Episcopal Church, Phoenix, Arizona, in which he sets forth his convictions on the subject. Portions are quoted below:

This parish at its Annual Meeting in January passed a resolution protesting the use of the National Council of the Churches of Christ as a political-action group. That is, we protested against the fact that the power of the Christian churches affiliated with the Council is being used as a lobby. We further protested that, although the impression is often given in the newspapers that the Council represents us, it is not truly representative; and it is not nearly responsive enough to the will of the constituent congregations.

Since that day, I have had no peace. On one side of me are the overwhelming majority of the clergy,

who favor the Council and do not wish it criticized. And on the other side of me are the laity of the conservative party in politics, who detest the Council and all its works, and who are particularly concerned over the reputed left wing tendencies of its hierarchy.

I am here to announce that the Church can never belong to either one of them. She belongs to God. And I would fight to the very end to prevent her from becoming, ever, the possession or the instrument of any political persuasion. The Church is in the world to serve God, not the Communist or the Republican Party.

I have never made a secret of my politics: I am a conservative. But neither have I ever affronted the conscience of this congregation by representing my politics as the Word of God. As a citizen of the United States, I am entitled to my political convictions. Indeed, as a citizen of this country I am entitled to fight for my political ideals by every honorable and legal means. But as a clergyman, I am sent to proclaim the Word of God. And my politics are no part of the Word of God. Neither have I any right to use my pulpit to preach my politics. If I preach the Gospel of Christ, I have authority. But if I represent my political opinions as from Christ, I blaspheme against Him, I disgrace my office, and bring His Church to ruin.

Law-Science Institute in Tenth Year

THE GROWING FIELD of knowledge which includes that part of law with medical significance and that part of medicine with legal significance is not only complex but is becoming more and more important.

The Law-Science Institute, which is sponsored by the Schools of Law and Medicine of the University of Texas, is dedicated to the promotion of postgraduate courses for lawyers and physicians, in order that the vast amount of legal and medical information pertinent to the field will become disseminated among all those who deal with personal injury court cases.

For 10 years one-week short courses have been conducted every February in Austin, Texas and at other centers over the country.

Recently the Institute has acquired property and established a summer school in Crested Butte, Colorado, a slightly ghostly mining town in the Rockies. Here a distinguished group of lawyers and physicians constitute a faculty for

a nine-week course which runs from June 12 to August 11 this year.

Each week's instruction is designed to form a complete course within itself. Separate weeks are devoted to the organ systems, head and vertebral injuries, orthopedic injuries, stress, cardiology and internal medicine. Each week stress is placed on trauma and disease, treatment and disability and legal medicine and medicolegal trial technic.

Vacation facilities for which the region is famous are available to the registrants and their families during off-hours and before or after the seminars.

Interested physicians may attend any one of the one-week sessions or any number of weeks desired. Fees charged for the courses are sufficient to cover only the expenses of the venture. The Institute is conducted as a non-profit enterprise. Inquiries may be addressed to The Law-Science Institute, University of Texas, Austin 12, Texas.

Medical Leadership in Rehabilitation

THE REHABILITATION of the handicapped person to his maximum capacity for functional, social and economic independence may require a coordinated process in which several professional groups participate. Some patients need only single services, such as physical or occupational therapy. Others require a comprehensive procedure beginning with a complete medical appraisal of the mental and physical status and including an analysis of the social background and the motivational factors and a vocational evaluation of employment potentials and capacity for retraining.

Whether simple or complex, rehabilitation begins with medical care, preferably concurrent with the latter rather than subsequent to it. Certainly, the physician is not the sole determinant of the full potentialities of the patient and he must rely upon the social workers, the therapists and the vocational rehabilitation counselors for their professional contributions. The physician is responsible for determining the level of mental and physical improvement the patient is likely to reach, the intensity of medical and other services the patient is capable of accepting and the time such services should begin. Likewise, it is his responsibility to the patient, throughout the entire rehabilitation procedure, to be certain that the latter's health status is maintained at an optimal level.

These medical functions are shared by all physicians, regardless of specialty, who care for patients with any disease or disorder which may leave a residual disability. Responsibility cannot be left for the very small number of physicians who have chosen physical medicine and rehabilitation as a specialty and have received board certification in this field as a mark of their exceptional professional competence. To this group must be assigned the responsibilities for the management of very difficult cases, for the organization of special rehabilitation services and for providing consultation to other physicians as necessary.

Unfortunately, there are many physicians who have not taken an interest in or accepted responsibility in regard to the rehabilitation aspects of their patient's medical problem. As a result, complaints of the following types are often made by nonmedical agencies administering rehabilita-

tion programs, such as vocational rehabilitation, sheltered workshops, or welfare medical care (Aid-to-the-Disabled):

1. Physicians frequently fail, either deliberately or by just not getting around to doing it, to provide the necessary medical information to assist the agency in determining the eligibility of the patient for the rehabilitation program.

2. Physicians often write down, "totally disabled," without reporting any clinical findings to back up such a statement.

3. When adequate clinical reports are submitted, physicians too often state that no rehabilitation services are indicated, when it is known by both medical and nonmedical members of rehabilitation teams that patients with similar types of handicap often show good responses to rehabilitation.

4. It is recognized that rehabilitation services are not adequate in many areas of the state. Yet several of the existing high quality facilities are having administrative and financial difficulties because they are not receiving sufficient referrals from the physicians in the community. On the basis of numerous studies of the prevalence of disabilities in a community, it appears that there are many patients just not being referred for available services.

5. When patients are referred, the physician's request is often made for a single service, such as physical therapy or occupational therapy, when it is obvious to those experienced in rehabilitation that the person requires a comprehensive evaluation. Such persons often have problems in adjusting to their disabilities, which may be intrapersonal or may relate to their dealings with their family or their community. On the other hand, it may be necessary for them to have a complete change in work habits or be trained for a new vocational field because the disability prevents them from returning to their former area of occupation. Thus, rather than a few physical therapy treatments a week, they should have a social evaluation and a prevocational counseling and testing service to be followed by actual vocational training if indicated. All of these services should be begun at the earliest possible time.

6. Physicians rarely consider the current labor market or the types of jobs available in the

community when recommending handicapped patients for certain jobs. The most common complaint by employment specialists is that physicians state that the patient is suitable for "light work," without having any idea of what "light work" involves. The classic example is the referral of a patient for a position as night watchman, when it is well known that the watchman must make rounds through a multistoried building every hour and be ready to take quick action in case of fire or intruders.

Related to this lack of medical leadership is the frequent tendency of many nonmedical agencies to take for granted that they are the leaders in the rehabilitation field and that physicians play a very secondary role, simply a source from which medical services may be purchased. This seems to reach a peak in the current Federal legislative proposal for a Federal program for "Independent Living Rehabilitation" (primarily a medical rehabilitation program for handicapped persons with no potentialities for return to employment) which would be placed in the vocational rehabilitation unit of the states. This bill (HR-3465) is being sponsored by the National Rehabilitation Association. In a widely distributed "background statement," this association declares that only vocational rehabilitation counselors have the philosophy and the experience to undertake such a program. While holding that rehabilitation for independent living is not primarily medical, the statement emphasizes that

the vocational counselors have had lots of experience in running medical programs, and are perfectly capable of doing so.

Thus we see here the pattern which is characteristic of phenomena in other areas of medical care. Whenever physicians fail to exert the necessary leadership in medical problems, there will be lay groups ready to step in and do it for them. It is still our philosophy that physicians should have the key role of responsibility for problems which are primarily medical.

Thus we must face the question of "who leads in rehabilitation." Medicine is not the only discipline concerned with the rehabilitation of disabled persons, whether the objective be employment or a maximum degree of independent living. However, the physician is a very important member of that team, and if he is not the captain, he would at least appear to be the quarterback. It is up to him to determine the medical potentialities of a patient and what the patient's mental and physical status will accept.

If the physician fails to carry out this role, there is the immediate danger of unfairness to the patient who may thus not achieve his full potentialities. There is also the long-range danger of handing over medical problems to nonmedical groups on a silver platter.—I. J. Brightman, M.D.; Reprinted, with permission, from the *New York State Journal of Medicine*, April 15, 1960.

Editorial Notes

The State of Michigan enacted legislation last year to implement the Kerr-Mills Bill for medical care of the elderly and retired. It became effective in November, 1960. It was anticipated that there would be approximately 65,000 beneficiaries in the entire state. In a little over four months of operation there have been 8,300 applicants, about one-eighth of what was expected.

In recent years it has become increasingly apparent that most auto accidents occur when driving conditions are excellent and involve automobiles which are in good mechanical condition driven by drivers who have no demon-

strable physical defects. A paper by Dr. John L. Benton et al. in the May 6 issue of *J.A.M.A.* stresses the importance of psychological testing prior to issuing driving licenses. Basis for the discussion was the performance of amateur sports car drivers. The psychological test given these drivers indicated that the drivers who commit the most driving errors also tend to reject social customs, are deficient in ethical awareness, like to take personal risks and are prone to abstract thought. Visual abilities and reaction times had no significant effects on driving ability. Race deportment, i.e., observing the rules, had more effect on the likelihood of an accident than either ability or experience, according to the tests.

President's Page

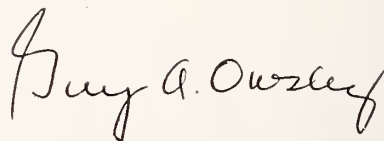
"LEST AULD ACQUAINTANCE BE FORGOT . . ."

One of the most effective activities of your state association was suggested many years ago by the chairman of our Legislative Commission (then committee), Dr. J. William Wright. In his proposal it was suggested that the chairman of the Legislative Committee and members of the Executive Committee visit the nation's capital each year, become better acquainted with our representatives in the Congress, and convey in a friendly way our viewpoint on any and all federal legislation as it relates to the practice of free medicine.

This activity has been carried on for the past 14 years, and it has been my privilege as a member of the Executive Committee for the past five years, to participate in it. When our assigned colleagues arrive in Washington their first duty is to pay a call upon each legislator and to become acquainted with their administrative assistants. In the evening following this assignment our state association invites each representative and senator, with their chief administrative assistant, to a dinner, usually held at the press club. This occasion is a high water mark in the humdrum of routine congressional duties, as expressed by all of our representatives many times. This is due not only to the opportunity it affords them of becoming better acquainted with our point of view, but it is actually one of the few times during the year when they see each other in their own group, and for this they are most grateful.

On the second day of this visitation we again review pending legislation in the congressional offices, and in the evening attend the dinner of the National Chamber of Commerce. On this occasion the 50 states hold their own dinners in the various hotels and the state groups are divided into congressional districts. This affords another opportunity to get together on a district basis and each of our state association representatives sits with his own congressman. As a result of this most profitable experience, many of our members have expressed a desire to help out at their own expense and to participate in such a way that we may have complete coverage for all districts.

It is difficult to estimate the effectiveness of such a project, but from one who has been granted this privilege on numerous occasions, I can only say that its increasing interest among our congressional leaders is testimony to the fact that we are accomplishing much in the legislative field for organized medicine, at least in Indiana.



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The Woman's Auxiliary

REPORTS TO ISMA



Traditionally the lazy summer days are laced with the pleasurable pursuits we enjoy with our families. Being aware, however, of the current congressional push toward enactment of legislation unfavorable to good medical care, we realize that we cannot afford to loll through these months in *complete* idleness. For this reason we are suggesting several activities that our members can incorporate into leisurely summer schedules.

OPERATION COFFEE CUP: Our Legislative Chairman, Mrs. Otis Bowen, reports that this project is perking merrily. Have you heard the Ronald Reagan recording that highlights the coffees? It is meaty bill of fare as well as a cogent eye-opener to the dangers of socialized medicine. Presented with force, vigor and clarity, it not only informs and convinces but also impels the listener to translate his reaction into action. Encourage your wife to participate in OPERATION COFFEE CUP. We must alert the public, whose intelligence we must never underestimate, but whose information we must never overestimate.

Marion County Auxiliary has the procedure worked out most efficiently. One member has a coffee to which she invites six or more people, one of whom is another Auxiliary member who has promised to take the recording home with her and have a coffee the following day. She, in turn, invites another group of friends, including, of course, the key member . . . and so on, thus keeping both the project and the record revolving in ever-widening circles.

AMEF CHRISTMAS CARDS: Mrs. William Symon, our AMEF Chairman, asks that the cards be displayed at all the coffees. We are fortunate in having an extensive selection of distinctive and attractive cards at various prices; they cost no more than they would if bought retail. AMEF receives the representative's discount; AND, as a special inducement, YOUR WIFE will be allowed an additional 8% discount IF she makes her purchase before August 15th. Please help AMEF by asking her to take advantage of this bargain.

AREA WORKSHOP PREPARATIONS: This, I fear, cannot be properly classified as a leisurely activity, for our officers and chairmen are all working hard in this direction. They are devising a portable program—one that can be easily carried home to the county auxiliaries. First of all, though, according to the circus maxim, we "have to get them in the tent." A word from you would undoubtedly help. And for that we thank you.

Eji Kentner

Maternal Mortality Study Committee

Report of 1958 Maternal Deaths Studied

*MATERNAL MORTALITY STUDY COMMITTEE,
Indiana State Medical Association**

THE FOLLOWING is a report of the Maternal Mortality Study Committee of the Indiana State Medical Association. This is the second report of the committee and is a report of the study of maternal deaths which occurred during 1958. The first report of the Committee was for maternal deaths occurring during 1956 and 1957.

The number of maternal deaths reported in Indiana in 1958 totaled 33**, which gave a maternal death rate of 2.9** maternal deaths per 10,000 live births. The 33 deaths were the fewest number of maternal deaths on record in Indiana, and 2.9 was the lowest maternal death rate ever to be recorded for the state.

The Maternal Mortality Study Committee studied 32 of these deaths (one was of an Indiana resident occurring in another state but charged to Indiana) plus 10 others in which pregnancy or childbirth was in some way associated. A total of 42 deaths were reviewed of which it was determined that 31 were from obstetrical causes, nine were not considered related to obstetrical causes and in two cases there was not sufficient information on which to base a decision.

As to actual cause of death in the case of the

obstetric deaths, 12 (39%) were due to hemorrhage, 6 (20%) due to infection, 5 (16%) were anesthetic deaths, 4 (12%) were due to toxemia of pregnancy, 3 (10%) were the result of amniotic emboli and one death (3%) was due to a pulmonary embolus. Table I shows the number and causes of death.

The deaths were analyzed from the standpoint of age. This is given in Table II.

The number of deaths in women 30 years and over is higher in proportion to the number of births by this age group than for the age group 29 years and under. This is, also, true for the women having their third or less pregnancy. The number of deaths by parity is given in Table III.

Continued

NUMBER AND CAUSES OF DEATH

CAUSE	NO. OF CASES PERCENT	
1. Hemorrhage	12	39
Ruptured uterus	5	
Abruptio placenta	3	
Post partum hemorrhage	2	
Ectopic pregnancy	2	
2. Infection	6	20
3. Anesthesia	5	16
4. Toxemia	4	12
5. Amniotic fluid emboli	3	10
6. Pulmonary embolus	1	3

TABLE I

The above percentages were comparable to the findings of 1956-57.

* Members: William G. Bannon, M.D.; David A. Bickel, M.D.; W. Donald Close, M.D.; Robert A. Garrett, M.D.; Charles F. Gillespie, M.D.; Carl P. Huber, M.D.; Elwood J. Meredith, M.D.; Mahlon F. Miller, M.D.; Edward B. Smith, M.D.; Vergil K. Stoelting, M.D.

** Indiana State Board of Health Reports.

Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

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Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

Your Cholesterol Depressant Diet Book

Menu plan for

Mrs. John Dae
DATE Feb. 1961

JOSEPH ROE

M.D.



1200 CALORIES		1600 CALORIES		1800 CALORIES	
URGENT CONTROL breakfast	1/2 cup grapefruit sections	70	TOTAL	30	30
	*Hard Egg	55		30	30
	Coffee or tea with 3 drops	15		30	30
				30	30
lunch	4 oz. tomato juice	75	TOTAL	30	30
	2 oz. drained tuna fish, surrounded with raw vegetables with 1 drop French dressing	75		30	30
	1 rye water	15		30	30
	Coffee or tea with 3 drops, skim milk	15		30	30
snack	(May be had at mid-afternoon or evening)		TOTAL	30	30
	8 oz. skim milk	90		30	30
				30	30
				30	30
dinner	*2 1/2 portion Priced Beef and 1 cucumber Salad	70	TOTAL	30	30
	*1 1/2 Baked Chicken Breast	315		30	30
	*Baked Asparagus	15		30	30
	1 canned peach and Coffee or tea with 3 drops, skim milk	15		30	30
snack	(May be had at mid-afternoon or evening)		TOTAL	30	30
	8 oz. skim milk	90		30	30
				30	30
				30	30

Menu 1
lunch substitution

USE THIS HANDY ORDER FORM

The Wesson People, 210 Baronne St., New Orleans 12, La.

Please send _____ free copies of
"Your Cholesterol Depressant Diet Cook Book" for use with patients.

DR. _____

ADDRESS _____

CITY _____ ZONE _____ STATE _____

MATERNAL MORTALITY

Continued

DEATHS BY AGE

AGE OF MOTHER	NO. OF DEATHS
Under 20	2
20-24	4
25-29	8
30-34	9
35-39	6
40 or over	2

TABLE II

Table IV gives the deaths by race and marital status.

As to prenatal care, 6 patients had none, 7 were seen during the 7th month or after, 6 had gone for prenatal care between the 4th and 7th month, 10 had gone prior to the 4th month and the prenatal care was unknown about two patients.

There were autopsies done in 17 of the 31 cases and there were 15 infants who survived more than one week born to these 31 mothers.

There continues to be a decline in maternal deaths in Indiana. Hemorrhage continues to be the leading cause of death with infection, anes-

NUMBER OF DEATHS BY PARITY

NO. OF PREGNANCIES	NO. OF DEATHS
3 or less	14
4 or more	17

TABLE III

DEATH BY RACE AND MARITAL STATUS

	MARRIED	UNMARRIED
White	25	1
Non-white	5	0

TABLE IV

thesia and toxemia following. Further reduction will depend on (1) prompt recognition and treatment of hemorrhage and conditions giving rise to hemorrhage, (2) use of consultation when complications arise, (3) careful choice of and administration of anesthesia to obstetric patients, and (4) continued education as to the importance of adequate prenatal care. The information assembled by the committee has been of great value in both undergraduate and graduate courses and programs.

CARL P. HUBER, M.D.
Chairman

WABASH VALLEY HOSPITAL

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A hospital for the treatment of Neuro Psychiatric Disorders
Open Psychiatric and consulting staff

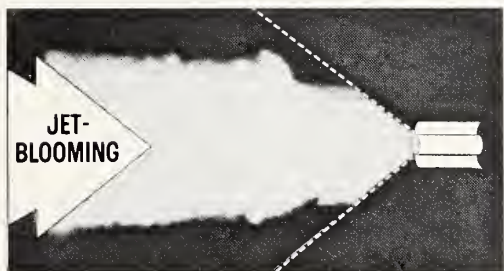
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Let's Tell the Truth

Dr. Edward R. Annis, Miami, Florida physician who spoke so forcefully on medicine's behalf, debating first against Senator McNamara, then Senator Humphrey, and finally skyrocketing to fame on two TV debates with Walter Reuther of AFL-CIO, appeared in Indiana on two occasions this spring to "... tell the truth."

He spoke to members and guests of the Indiana Health Organization for Political Education at special banquet programs in Indianapolis and in French Lick. Excerpts of his Indianapolis address, given on April 25, are printed herewith.

EDWARD R. ANNIS, M.D.

Miami, Florida

I'm not really here to make a speech tonight, but here rather to talk about some of the things that we all know to be true, but that we sometimes don't think about. . . . To talk about some of the answers that we tried to give to Senator Humphrey and to Mr. Reuther. We weren't really trying to give them the answers, but to give answers to the captive audience that these men assured us of having.

We wouldn't have had anywhere near the millions viewing these debates had it not been for the very liberal senator from Minnesota, and then especially, when we had the good fortune of meeting Mr. Reuther. These people assured us of a listening audience.

I've had doctors say, "Why didn't you jump on Reuther for his socialistic background and the rest?" Because I wasn't there to argue with Mr. Reuther. I was there to try to put some of the ideas before the American people that they haven't heard . . . to reiterate some of the things that we know are right and should be said, hopeful that as some people listened they'd realize they had been denied the whole story and that there is another thing to be told, and would be more willing and more able to listen and understand our story.

Mr. Reuther says we want to take care of our older people in the autumn of their lives and we go for it, because we all want to take care of our elderly people. We don't want to deprive them of anything. But it's the easiest thing in the world for a demagogue to get up before an

American audience and say this great nation of ours has more of this, that and the other thing than any nation in the world, and there is no reason why any of our senior citizens should be deprived of the modern medical care of which we are so proud. It's easy for somebody to propound this sort of a speech, to make it understandable and intelligible. But what the people sometimes forget and don't realize, and you and I too, is that we are swept along with a slogan or with a realization or we bemuse ourselves that merely *thinking* well and having ideas about something and agreeing that something is a good idea—is the solution to our problem.

What are the facts regarding medical care? What do we have to tell the people who say medicine costs so much? Medical care today has gone up so high that no one can understand it. I've had members of the House and Senate say, "Ed, I'm with you. I think it's wrong to do these things, but I've got an uncle or an aunt or a cousin or a sister or a brother or someone else." They said Sam Rayburn himself had such an experience. Senator Kerr had an experience in his own family, and they go on down the line. They say something has to be done about this high cost of medical care—as if it is something we just pile on without any reason.

Being Approximately Correct

As physicians and as Americans we should have an answer. When someone makes these statements it reminds me of the old story about

LET'S TELL THE TRUTH

Continued

something being approximately correct: a fellow met an old friend one day and he said, "Hello, Joe, I haven't seen you in ages. I heard you made a million in oil."

And he said, "Harry, it is good to see you again. It's been a long time. What you said is approximately correct. But it wasn't me, it was my brother. It wasn't oil, it was steel. He didn't make it, he lost it."

But it's approximately correct. In talking to civic and to non-medical groups about the cost of medical care we do like to hit a few things. And I remind these people that we don't practice horse and buggy medicine any more. Nor do they have horse and buggy transportation. It's true that in the days of horse and buggy we had doctors who were devoted to their patients and did everything they could. And also in those days it took a long time to go from Miami to Indianapolis. But today I can ride a jet from Miami to here in very few hours. And one jet in one day can bring more people from Miami to Indianapolis, and transport them three, four or five times back and forth, than a hundred horses and buggies could have done in two or three weeks not so many years ago.

We talk about the great advances in scientific developments in other fields. Down at Cape Canaveral they have a rocket that they can shoot at a target 4,000 miles away and hit, nine times out of ten, that target which isn't bigger than the building where we're meeting tonight. And we say, "Isn't this marvelous?"

What we as physicians have forgotten to tell you is that while these marvelous advances have been taking place in every other field of science and industry, same and parallel advances just as miraculous in character have taken place in the practice of medicine.

Many of you have practiced longer than I, but I went into practice before sulfanilamide came out and certainly penicillin and all of the rest.

We used to see and treat diseases that killed off youngsters and killed off their parents that today aren't even seen by any of our young students.

We are proud of what has been accomplished, but we haven't been telling other people about it. They like to watch television and see a heart operation, but they don't realize how many people are involved in this and what has taken place

and how, because of the great advances in the field of medicine and the field of physics and biochemistry and all of the rest; the advances in anesthesiology and the laboratory and the antibiotics and everything. We do things today that even we think are miraculous compared to what we could do 10, 15 or 20 years ago.

One of my friends was talking about antibiotics the other day and he said, "You know, Ed, they keep coming out with these new antibiotics and I not only can't keep up with the names, but I understand they've got a new antibiotic for which there is no known disease."

Talking about drugs. You know Senator Kefauver was up for re-election last year, and there's a rule in the Senate on the part of some of these second-rate senators that if you're going to run for election you have to have an investigation some place. One of his investigations took him into Miami because this kind of senator, when he has an investigation, always has some reason to come to Miami in the winter. And of course you helped to pay the bill.

Senator Kefauver asked, "Why is it that I can buy a capsule of achromycin in Cuba for 20 cents and I have to pay 50 cents in Miami?" He went on to say that it shows that the druggists are making too much money, that the pharmaceutical industry is making too much money; everybody is soaking the American public and this is why medicine costs so much. And I think I probably told him the story of being approximately correct. I invited him to just look a little bit further. What about these drugs? For every 100 drugs that have been researched in this country, 99 are discarded, but the research has to be paid for. Some of them would be potent and kill off disease but they'd also kill off the patient. So we not only have to find something that can kill disease, we must make it safe. This costs money.

When we buy a drug we're not only paying for the research in the past which made it possible, but we're paying for the continuous research which will make even more and better things available to the American people.

Take any of the great pharmaceutical companies of this nation and you can point out that many millions of dollars are spent before the first injection or the first capsule is given to an American, after it has been made safe. All of this costs money. But we are a nation of kind hearts

and gentle people. When we've learned the formula we've gone to Cuba and other countries and given them a way to protect their people, to eradicate disease. They reproduce it according to the formula that was developed in this nation, with Cuban labor, and distribute it with Cuban labor. What laboring man in this country would recommend that our great pharmaceutical industry pay the labor that is paid in South, Central and Latin America, generally?

What labor leader would dare to recommend that we lower the prices of these drugs by bringing our labor down to this level?

Greatest Cost Is Labor

These are the things they don't tell us. They don't tell the American people that the greatest cost of medicine today in the hospitals and the doctor's office as well as in the pharmaceutical industry is labor, which absorbs anywhere from 75-80% of the total cost.

All we're asking them to do is tell the truth. Tell the people the other side of the story. The American people are basically honest if they are honest with themselves. They don't ask just what does it cost—they say, "What is it worth?"

A couple of weeks ago I had a little girl, and all of you can tell stories like this because you don't have to reach out and make up stories. You have the true stories in your own practice. This little girl of seven years of age was from a family of five or six much like my own. A kid could be sick a couple of days and if she didn't complain you wouldn't know it. This little girl of seven had a tummy ache, but her family didn't pay much attention. When we saw her she had a ruptured appendix and a temperature of 104°.

We put her in the hospital and took out her appendix, sucked out some of the peritonitis resulting from it, put some medicine in, gave her medicine in the veins for a couple of days. She had no abnormal temperature after three days, then was put on medicine by mouth and left the hospital on the seventh or eighth postoperative day.

The drugs must have cost \$30-\$40, maybe more, maybe less. But I'd like anybody to ask the parents of that youngster how much they were worth. We don't say how much does it cost but how much is it worth.

How many people in this room today know of those who died before we had these marvelous

drugs? We didn't call them miracle drugs and neither did the drug industry. They were called miracle drugs and so labeled by the American people who saw people live and come out of a hospital when in the past they would have died.

I particularly can appreciate this because my own father died of a ruptured appendix in the days before these drugs were available. Don't ask how much does it cost, but how much is it worth.

What did their absence cost us in lives? . . . in members of the families of many of you who are here tonight?

So we say to those who point a finger and talk about the high cost of medical care, tell the whole truth and let people look at the other side of the story.

The story of medicine and the progress of medicine, what it has meant to the people of this great nation and what it has meant to those to whom we have exported results of our knowledge, is something for which we can be justly proud.

Still others come along and they say, "Well, doctors charge too much. You doctors have big fees."

You know, it's a funny thing. When people talk about what most people make they talk about what their income is, like an airline pilot who makes from \$12-15,000. But you know a doctor has to collect between \$25-30,000 to make the same amount. They'll point to the pilot and say he makes \$1,000 a month. And they'll point to the doctor in the same room at the same cocktail party and say that he makes \$25,000 a year. And the other one makes \$12,000. The truth of the matter is that the take-home pay of the pilot is much more than the average doctor who collects \$25,000 and has to get \$30,000 to make it.

Some of our enemies now and then try to undermine us, and yet, in so doing, they admit that some of these things are true.

Within the past month or six weeks there was a book published called *The Case for Socialized Medicine*. The name of the man who wrote it is Tucker. He's a member of the Socialist Party. He talks about the opposition under the headline, "What Ails Doctors?" Then he goes on and tells us what ails us.

But this he does say: One privately practicing American doctor out of eight makes \$30,000 a year or more. Of course he doesn't tell you

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what the taxes are. He does say that four out of five earn more than \$10,000.

In 1955, according to *Medical Economics*, the median income for private doctors was \$16,000 before taxes, and for all specialists it was \$18,000. And he says, "Believe it or not there are some arguments that justify doctors' getting this kind of money. For one thing it represents an average work week of slightly more than 60 hours. If the typical doctor's income is calculated in terms of hourly rates with overtime and double time for Sunday work, it comes out on a base pay of \$4.13 an hour. This compares with \$4.25 an hour base pay for union brick layers in New York City."

And this Socialist goes on to say, "True, brick layers don't manage to work 60 hours a week. They're lucky to work 40 hours. But then if brick laying is a skilled craft, medicine is more than one."

Comparing Doctors' Earnings

I've told people time and again in Miami, and I have offered them a wager that if, of the doctors that I know, the great majority were paid the wages that we pay in Miami for a master carpenter, plumber, electrician and especially a tile setter, their take-home pay would be one and a half or two times what it is in the practice of medicine.

So you say Mr. Tucker is good, he's telling the truth. And then he goes on and says, "Furthermore, these figures represent doctors' incomes during their payoff years. Before a doctor makes this kind of money he must spend four years in college, four more in medical school and a year as an intern. The last year he gets subsistence wages. The other eight years he pays out money. To become a specialist he must put in three to seven more years to study as a resident, then he still has to set up practice, often buying it. He has to buy equipment. He has to wait for patients. If he's a surgeon he's already nearer 40 than 30 with the prospect of early retirement because of the strenuous demands of his specialty. He'll probably be well past 40 before he gets out of debt."

You know this sounds like I wrote it. Then our Socialist friend goes on and says, "These are the facts of a doctor's economic life and they are his justification for a high rakeoff when

he finally gets going. And if he hates and fears socialized medicine, it's because he believes that a government-administered system would fail to understand these facts and would seek to slash cost by cutting his income."

Let's read the next paragraph which finishes up the section on what ails doctors. He says, "Advocates of socialized medicine need to provide an answer to this fear of doctors. And there is an answer. One that makes good sense and carries inherent conviction, which is that under socialized medicine, medical education will not require the extreme sacrifice it now requires because the government is going to pay for it. And there will be no more buying and selling of practices and waiting for patients." And that "until such a state of affairs has come to pass doctors should continue to have a high average income level."

Why doesn't the public know our story? In the first place we haven't told them. In the second place we have to quit talking to ourselves and talk to our friends and talk to our patients. We have to become interested in civic affairs because this is an opportunity in the market place to meet people in every other field of endeavor. And as I tell my doctor-friends, wherever they are, there is some civic club that can be made to order to appeal to some doctor everywhere . . . because Rotary own the town, Kiwanis run the town and the Lions enjoy the town.

We can be active in PTA organizations, church groups. Church groups are so important because the do-gooders appeal to them. They get many of our religious leaders, cajole them, talk to them and give them a snow job into saying that this is good, this is great. "We all want that," and these groups nod their heads "yes, that's what we want." Then they slip in the bill that really throws it to them that they aren't aware of. People don't know they've had this snow job.

They're doing it at the present time in all groups. They go to some of the large organizations that have religious hospitals and they are wooing those that run them today on the basis that the government is going to pick up the deficit that they have.

Take Time for Public Relations

Why have we been ineffectual? Well, you say we have poor press relations. That's true. The COPE organization, the Socialists, the politicians

and the rest, seem to have pretty good public relations.

Time and again we get criticism from newspaper reporters and from others. The doctors are too busy. We cast media aside, we have no comment. We don't take the time. We say why should they ask these questions. They can't understand them anyway. I try to tell my friends, remember that they're just trying to do a good job.

If the person who lives next door, your own neighbor, asked you what diverticulitis was, what would you tell him? "You wouldn't understand?" Or would you take out a pencil and paper and draw a little bit and tell him a little bit about the old-fashioned innertube when you put air into it how it would balloon out on one side. Or any one of a number of illustrations? But you'd take a little time and a little patience. And you would put it in simple words that he could understand.

If we'll just take this kind of time with the people who work with the press and radio and television, we too can get a good press. We too can get these people to work on our side. Because we have been nice enough to them, ladies and gentlemen, in dealing with the members of the press who also are trying to do a good job.

And so it's not enough to sit back and damn the press for the way they write the things that we tell them or the things that we say or the things that we do . . . unless we help them to interpret it.

Dangerous Complacency

Our greatest vulnerability, however, it seems to me, lies in two fields. One, complacency. I've heard doctors, right here in Indianapolis, and a couple of days ago in Galveston . . . they say, "Well, Ed, it's not going to go through this year." They read it in *Time* or someplace else. "We have nothing to worry about."

To these people I would remind them that within the last week the President of the United States, the Secretary of HEW, Mr. Ribicoff, Senator McNamara of Michigan, Senator Proxmire of Wisconsin and Senator Humphrey of Minnesota have all said we're going to push it through this year. *This year.*

Mike Mansfield yesterday was reported in one of the Indianapolis papers as saying that they are maneuvering around now and are hopeful that they can tie it on to one of the social

security amendments. And for those of you doctors who don't know it, the President of the United States called Mr. Wilbur Mills of Arkansas to the White House three weeks ago and offered him a federal judgeship which would give him an income for life, would give him security for life. And if Wilbur Mills of Arkansas were to accept that position, Cecil King of California would become the Chairman of the House Ways and Means Committee and the social security bill would be pulled up the same day.

Complacency has no place today because this isn't the way things are done in Washington. Anyone who thinks we can sit idly by because *Time* or *Life* or any other magazine says there is nothing to worry about this year . . . there is nothing to worry about *providing* we continue to work.

I also received a letter last Thursday morning from my good friend Senator Smathers. And he said, "Ed, I think you can beat it this year only if you continue to work."

Because he said it won't get through the House Ways and Means Committee if it follows "legitimate channels."

These men aren't following legitimate channels in some of the things they are trying to do to medicine today. There is no room for complacency. It's time that we go to work. And it's time that we work as consistently and conscientiously and as energetically and as continuously as do the members of the COPE organization.

Fragmentation vs. Common Problem

We have another vulnerability: we lack an united front. We have conflicts between special interests within our own profession. Conflicts which dissipate our strength and magnify our weakness.

We have fragmentation of medicine fighting among ourselves in too many instances. And at the same time we have a common problem in Washington and in this nation today. Unless we have unity of purpose on this one thing we will never get anyplace.

Senator Kerr spoke to the representatives of the medical profession in Chicago a couple of weeks ago. He's a big fellow; he can talk very blunt and very direct. And he put his chin out and he said, "I won't say you're all good because you ain't."

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He briefly referred to some of the shortcomings of physicians. The surgeon who charges unconscionable fees, who as a policy demands payment in advance of his surgery, who sets his fees, as one I know, by multiplying Blue Shield five times—these men are veritable bloodsuckers draining the lifeblood from American medicine. The intern or diagnostician who takes an EKG and a blood cholesterol, listens to the heart and thumps the chest and stops there—supposedly a complete examination, but then because he is a super specialist will charge an average working man or woman \$75-100, is rendering services neither to the patient nor to his profession. And too many of these same kind of men will then refer the patient to an eye, ear, nose and throat man to look at his tonsils, to a gynecologist, to a proctologist so that he or she can finally get the complete examination.

And a parallel and an equal disservice is rendered by those general practitioners who attempt to use the growing professional and political strength of the Academy of General Practice as a lever for privileges not earned by study, training or experience.

Technical Skills Not Endearing

You and I know that the vast majority of doctors would not fall into any of these categories. But in the minds of the public a family doctor is not determined primarily by his type of practice. Warmth of heart, human understanding, a sincere desire to help those in need of our help. These and not our technical skills are the things that endear us to our patients.

You take good care of your patients and they'll take good care of you. If we take good care of the American people and tell them the truth, they'll take good care of us including the way they vote.

Well, now with all of this as the background, what's the immediate problem? We are opposed to the social security approach of financing, first as citizens and secondly as physicians.

In the first place, let us look at Social Security. This is a tax, it is not insurance. It has so been held by the United States Supreme Court. The taxes which are paid today are made available so the government can provide benefits to the people who are receiving them today. There is no actuarial stability to the Social Security system.

The reason that it is fiscally sound is because of the ability of the United States government to levy taxes. And it's the only way that it can pay.

If we added no one else to the Social Security from this day forward and only paid those who are today receiving Social Security—for every dollar in reserve fund we're going to have to come up with \$18 more.

We have \$20 billion and we're obligated \$360 billion.

In 1957 fiscally, and some of you have heard me quote these figures to Mr. Reuther, the Social Security system paid out \$126 million more than it took in. In '58 it paid out \$528 million more and in '59 it paid one billion seven hundred and twenty-four million more than it took in.

Last year with the half percent rise in Social Security it got an extra billion dollars and it paid all of that out but \$180 million.

Not Insurance, but a Tax

The Supreme Court of the United States has said this is a tax. It is supporting a welfare program.

So when Ribicoff or the President of the United States or anybody else says that this is insurance, that this is pre-payment, that when a man pays into a system, he's putting in deposits that are sent to Washington and kept there for his old age, they are not telling the truth. And what's more they know they are not telling the truth.

And if you are one who sells drugs or sells food and you put things out on labels like the various drug stores or groceries in this or any other community, and you mislabel it the way they're mislabeling Social Security, they would call you into a federal court. It's unjust, it's unfair and these men are not telling the truth. We have a right to expect more from those who are in the position that they occupy in our government.

Not only that, but the Social Security approach to provide medical care is a departure from the Social Security system, because Social Security says it is going to give you dollars when you become older to spend as you need and want. But the Social Security medical program says that the government shall provide these services in hospitals under contract with the federal government and the rules and regulations prescribed by the federal government.

Under the Social Security approach it would benefit everybody who is over 65, and recipients of Social Security are eligible for it including the million over 65 who are still working, whether they need it or not, whether they want it or not.

So the position would be that if they pass any of these Social Security bills, the working people of today and their employers would pay taxes and the 11 million people who are over 65 receiving Social Security would never pay a nickel as long as they live for their medical care.

Under the King-Anderson Bill they would pay the original \$90 deduction. But I'm talking about putting it into the tax fund out of which the whole program is supposed to be financed.

They talk about the means test. They say it's so mean to people to have to subject themselves to the indignity of the means test. How many of you can open a charge account in any store in Indianapolis without a means test? How many of you can charge anything without a means test?

The unemployment extension bill which is now being made available to people who are unemployed is only after all, a means test for those who are in need and have become unemployed.

Scholarship, which was included in the same program when Kennedy presented the King-Anderson Bill . . . they said we're going to have scholarships for dental and medical students who cannot afford it, for needy students. A means test. Under public housing, we have an attorney in Miami who is constantly trying to socialize the practice of medicine. This fellow says it is not dignified to have anybody take a means test. So he gave a report before the Senior Citizens Division of the Welfare Planning Council and I was there. And he told about government housing, socialized housing, told about how wonderful it was. That these were very costly, very expensive and that public housing of this kind needed the help of private industry, churches and everything else plus the government because each addition is costing \$25,000 to build, and they were going to rent for an average of \$25 a month.

And so in the question and answer period I got up and I told him, "I've got a lot of older patients, many of them over sixty-two. Were they qualified for public housing? What do you think about my having them sell their homes that would be worth anywhere around 4, 6, 8,

10, 12 thousand dollars and put it in the bank because then they'll have a good nest egg and then move into one of these public housing developments and pay \$25 a month."

He said, "Oh, you can't do that."

And I said, "Why not? If they're over 65 or over 62."

He said, "Well, they wouldn't qualify."

I said, "What do you mean they wouldn't qualify?"

And he said, "Well, they have to have an income below a certain level and assets below a certain level."

And I said, "That's a means test."

He said it was beneath the dignity of the American people to be subjected to a means test. It's not beneath their dignity to be subjected to a means test to obtain Social Security in the first place, and state that they're not making so much income in any one year. It's not undignified in any other field except this and they're using it as a political lie because they're not telling the people the truth. That's what they've been doing.

The King-Anderson Bill is a bill which is connected with Social Security. It's a limited bill. It has a deductible clause whereby people have to pay \$10 a day for the first nine days. It's a boon to the wealthy. It would be a tragedy to those who are in a difficult position with their income and can barely get by. They'd have to come up with \$90. But the almost eight million people over 65 who have their own insurance can drop it, pay the first \$90 and get the rest with the taxpayers picking up the bill.

A Foot in the Door . . .

It should be exposed for what it really is. Representative Forand says that this bill doesn't go far enough but it will give us the foot in the door and we'll expand it in every direction.

The COPE organization of the AFL-CIO says that it will establish a framework upon which we can build, and build and build until every man, woman and child in America is taken care of by government expense.

When I was in New York debating Senator Humphrey I picked up the December 1st issue of the supplement to *New America*, the official publication of the Socialist Party. What do they say?

"The limitations will be only the limitations of Social Security itself. This bill will not be

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paid for on insurance principles, according to factors of estimated risk. It will be paid for through the tax mechanism of Social Security. But once this bill is passed," the Socialists go on, "the nation will be provided with a mechanism for socialized medicine capable of indefinite expansion in every direction until it includes the entire population."

And they go on, "And it is already evident that there will be massive pressures in favor of such expansion."

This is what Forand says about it, this is what COPE says about it, this is what the Socialists say about it.

They have built into this a divide and conquer technic which has long characterized the work of Wilbur Cohen and others in Washington. The Wagner-Murray-Dingell Bill was unsuccessful because it covered too much ground. They were going to socialize all of medicine and have all doctors work for the government.

The Forand Bill came along, and this guy Cohen is pretty sharp because he wrote it, you know Forand of Rhode Island didn't write his bill. It was written for him by the AFL-CIO writers with the assistance of Mr. Forand and the former congressman from Wisconsin, Mr. Bieniller. These are the men who wrote his bill and Forand admitted it.

The Forand Bill was written in a divide and conquer technic. They were going to pay surgeons but nobody else. And in Washington my good friend told me, "You know, Ed, what they figure is that by the end of the year, the internist, the heart man and the general practitioner will say if you're going to pay those so and so surgeons there's no reason why we shouldn't get paid. A built-in divide and conquer technic to pay one class and not another . . . to pay one group for services rendered and not another. And even that says that only those surgeons would be paid under contract with the federal government and the rules and regulations set down by the federal government and in the amount paid by the federal government and no one could charge more than the rules and regulations of the federal government irrespective of the income of the individual.

I'll give you an absurd example. Arthur Vin- ing Davids is worth several hundred million dollars; he lives in Miami. And under the pro-

visions of this bill, because he was over 65, if he chose to have taken it, he could have any operation performed and the total fee that could have been charged by anybody—his lawyers might get a half million dollars, but a doctor who might save his life in an operation would be paid what the federal government said and by federal law he might not charge one extra dollar. How absurd can you get?

These are the things they have written into this bill, and now they've got a different angle. The King-Anderson Bill is written to get the hospital men and the full-time men and the men who are working in medical schools and in teaching positions that are on a full-time status. It is built so that these people now will be able to see an opportunity to expand their clinics, expand their operations and have the government pick up part of the bill.

Ribicoff says that doctors won't be paid and it's not socialized medicine because the government isn't paying doctors. But he's not telling you the truth, because the provisions of this bill are that the hospitals can be paid for the services of interns and residents, the doctors who work in outpatient diagnostic clinics and the anesthesiologist, the pathologist, the men who do physical medicine and the x-ray men providing they are in a hospital.

And they tell this man over here in an x-ray office across the street from the hospital, if you take care of any of our older people and you x-ray their gallbladder or stomach or whatever it is, we won't pay you. But if you work over here in this hospital we will pay the hospital and they'll pay you. And they'll pay according to the rules and regulations prescribed by HEW in Washington.

We have men, I had one at Baylor University, a couple of weeks ago come up and say, "Ed, you made a good speech. I think you're right. I'm along with you but of course it doesn't mean much to me because I'm in full time medicine over here."

And I said, "Let me remind you of something. I don't know what you make. It doesn't make any difference. But this I do know because I've had a little bit to do with getting of professors and other people in the last few years. . . ."

When industry goes to hire doctors and when medical schools are looking for deans and heads of departments, and for clinicians and someone

that they can depend upon, they first look for a man who has done well in competition with his fellow man. And they say we want this fellow because he's got this ability or that ability which has been demonstrated in this competitive system of ours. The next question is how much do we pay him. They judge how much this man is worth on the basis of what this man would make in private practice, on the basis of what men of comparable training are making in private practice. And they say in private practice he'd make \$25-30,000 a year. When he gets through running his office and all of the other worries and things that are connected with it, he's lucky to have a take-home pay of \$12-15,000. And for a man to be saved the responsibility and the worry of running an office and all the things that are connected with it, and for a man in a teaching position and the things that he has to do he should be saved all those things. But for a man in that position to get \$10,000 is the equivalent of making \$25-30,000 in private practice.

When the day comes that we don't have as a yardstick the income of the men in private practice, then if the job pays \$10,000 there will be 20 people there, just as able, who will do it for \$9,000. And if it pays \$9,000 they'll do it for \$7,500 and if it pays \$7,500 they'll do it for \$6,000 as they're doing in other countries.

So don't ever feel those of you who are not in private practice that what happens to the private practitioner of medicine in this free enterprise system is no concern of yours. Because the very position that you hold in most of the institutions of this nation is determined by what is still basic in private enterprise. And your worth is measured by the worth of these men.

We have need for unified action. We are ruled by ideas and very little else. Teddy Roosevelt some time ago issued a challenge. For many years it was over the editorial page of the *Marquette University Bulletin*. That's where I learned it when I was in school. I read it so many times over the five years that I was in Milwaukee that I should have remembered it. It was a real challenge because it says "Vigorous fighting for the right is the greatest force the world affords." We've got a real fight.

Success in Individual Contributions

Our ultimate success is going to depend upon what we do as individuals. What we do to contribute to a coordinated, united effort to get

facts before the American people, in our practices, in our local medical societies, in our county medical societies, in the American Medical Association. And if we don't like the policies which are being determined, which are being put forth by our leader, then it's up to us to become active ourselves and change the policy.

But to the extent that we are too busy, and being busy is no excuse for neglecting the responsibilities of citizenship, then we at least should have the common decency to have some feeling of courage and give a feeling of courage to the leadership that is doing it for us.

We have to let them know they have our confidence and our support. It's going to take a great amount of united effort. It's going to take a great amount of money.

We pay the AMA \$25 a year. A good friend in Miami runs a transport line. He tells me every month he has check-off dues of seven dollars a month for Hoffa's Teamsters' Union. Eighty-four dollars a year for one union and one small branch of the union. And we're dealing with unions today that have in the total Social Security fund in Washington over \$20 billion, but in the total reserve of unions today in Washington is in excess of \$42 billion, or twice as much as is in the entire Social Security reserve system.

Pennies Combat Unions' Millions

We are dealing with people that have millions at their disposal to fight this battle and we're trying to do it with pennies.

We cannot do the job unless we hire people to do the job for us. We have to contribute thought, we have to contribute action, we have to contribute a whole lot of ourselves and we must contribute support for our leaders.

Kerr-Mills Sound in Principle

What do we have to offer? The Kerr-Mills Bill is sound in principle. The Kerr-Mills Bill which we have been for is based upon the principle that doctors determine medical needs, the local community determines the financial need and the only role of the federal government is one of granting aid to give dollars to states to help them take care of people who need help.

We think this is good. When Senator Byrd presented it before the Senate he said this was a good bill. It has come as a result of many weeks' deliberation in the House Ways and Means Committee and the Senate Finance Com-

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mittee. This bill is designed to take care of the needs of any of our older citizens in this nation who need help and it will take care of everything that they need. It won't be a limited bill like these other bills. It will take care of everything that they need. The taxpayers of the nation will be taxed only to the extent of helping people who are in need of help. They will not be taking care of people who are well able to take care of themselves.

It's our responsibility, too, to encourage the great insurance industry which has made tremendous strides in the field of health, making health insurance available.

It hasn't been very long since we had relatively few policies in this nation. I know you'll be happy to know that today we have 127 million people covered for hospitalization. We have 112 million who are covered for some type of surgical coverage; 75 million for some type of general medical coverage. And we have 17 million that are covered for major medical catastrophe insurance. We have almost eight million, the figure was 7.7 about four months ago, of people 65—7.7 million people over 65 years who have some type of insurance which reflects their ability to pay their own bills.

But our problem is one of telling our situation to the people. And bringing some of these things to the people who will know and understand it. Because as we learn more and as we have wider experience and as insurance companies have wider experience they'll do an ever better job, in making available to the American people the way that people can help themselves.

The real issue, however, is one of the preservation of our freedom. There are two things that I would like to call to your attention:

One is an article in yesterday's *Indianapolis Star*. And for fear some of you may not have read it, it's headed Monday, April 24, "Churchmen Confess Socialistic Leanings." Why are the communists winning the cold war? Because a considerable part of Christian leadership has embraced socialist ideology. This has long been true in Europe and to a lesser degree in our own country, but it is now confessed openly by American churchmen, occupying high positions.

The *United Church Herald*, February 9, carried a startling statement by Nels F. S. Ferré,

avid professor of Christian theology, Andover Newton Theological School. Dr. Ferré says his "hope and goal is that the Christian forces disassociate themselves from capitalist ideology and strike confidently for a social economic and political order that envisages true democracy and that makes world peace its immediate goal." Thus he repudiates capitalism and takes his stand for socialism.

The communists are winning the cold war because so large a part of the leadership in Christian educational, cultural and commercial circles has lost confidence in a society which emphasizes individualism, self-reliance, private ownership of property, incentive, reward for effort and profit, and steadily is pursuing Marxian ideals. We have crumbled from within. No wonder Khrushchev gleefully declares that war is not necessary to usher in a socialist world. Both in Russia and in the captive state countries I've heard high communist officials with complacent self-assurance tell me that we already have gone so far towards socialism that there is no turning back. That they will not have to prod us but only to wait a few years until we voluntarily come into their camp.

We heard Khrushchev say that our children would live under communism and a lot of people think he was kidding. I remember when *Mein Kampf* was first spread around, a lot of people said it was the work of a madman, it was stupid, but what has happened? I'd like to close quoting directly by that great physician, congressman, statesman, Walter Judd of Minnesota.

He was talking to doctors in the East on "Physicians in a Changing World" and he said, "For what main purpose did the founding fathers originally come to this country more than three centuries ago? To establish a government that would look after them? No. They came here to get a chance to provide for themselves. The system worked. But it is under determined assault today, here and everywhere around the world. Adhering to that philosophy of government the pioneering fathers built a society that released as has never been done at any time in any place the creative capacity that is in ordinary people everywhere. The greatest outbirth of creative effort, imagination, invention, energy, production and progress that the world has ever seen took place here."

And there are people today who say what's a

one percent increase in Social Security tax? And I answer businessmen this, one percent taxes two billion dollars out of the American economy. One percent. The government creates no wealth, it can only have wealth after you go to work, and at the end of the day instead of getting that money to spend as you please they take some of it away from you and they give it to someone else. And a one percent rise is two billion dollars. That's a thousand million dollars taken away from industry that cannot repaint, retool, replace old equipment with new, make new jobs, create jobs for the American people. And it's a thousand million dollars, a billion dollars that's depriving the American people of money that they have already earned that they cannot spend because the government takes it away from them.

So when they talk about a little one percent rise, one percent takes two billion dollars out of the American economy. This is what has happened in England. This is what has happened in New Zealand. This is what has happened in a great number of other countries.

I grew up on the east side of Detroit. I remember when Henry Ford started paying five dollars a day. They talked about mass production. Ford said you can't have mass production without mass consumption. And we don't have enough rich people in this country to buy all the automobiles we can build. And the only way that we can be great and the only way that we can continue mass production is mass consumption. And that means that the average worker, when he gets through paying for his food and his clothing and his shelter, has enough money left over to buy automobiles that he helps to make. And that's also true for the radio, the television, the deep freeze and all of the other things that our American people have.

And only to the extent that they have this much money after taxes that they can buy these things in a free economy, can we continue to grow as a great nation.

Let us look at England on this basis. Thirteen years ago they said when it was fully operating their English system wouldn't cost over \$500 million, but last year, its thirteenth year, it cost two billion, four hundred million or almost five times as much.

In the 13 years of its existence they have built one hospital in all of England, with 30 beds. In

the United States of America we built 724 with 202,000 new beds.

In this same period of time in England what else have we seen? Thirteen years ago, in this country there was an average of one doctor to every 750-760 people. And that's still true today. People will tell you that we're not graduating medical students and that we've tried to cut down the number. They aren't telling you the truth. In 1930 we graduated 4,600; in 1940, 5,200; 1950, 6,400; 1960, 7,200. And we have continued to keep up the number of doctors with the number of people.

And in England where they had one to 850 13 years ago they now have one to every 1,147 because doctors are leaving England and their sons are leaving England.

We have some 8,000 students studying in this country today from other countries. And what are they doing, most of them? They're not asking for visas, they're asking for citizenship. They want to stay in this great nation of ours, under the greatest economic system that has ever been known, as Dr. Judd refers to, but also the greatest system of medical care that's ever been available to any people under the sun.

These are some of the things. How do they pay for this other 76 cents in England? And the reason that I departed was to remind you of the principle of the American economy. They pay for it in excise taxes, primarily. The excise tax on most automobiles is 66 2/3%. You buy a \$3,000 Ford and it costs you \$5,000 because the tax alone is \$2,000. The tax on luxury goods, on cosmetics, on furs, on jewelry, on leather goods and all electrical appliances is 100%. So if you want to buy a hot water heater that costs \$150 it will cost you \$300.

Little Economical Difference

There are few doctors here tonight that whether they socialize us tomorrow or pass any of these bills would find it would make a great deal of difference. It would make very little difference in our practice, no difference in our income. We might have a few less hours of work because somebody else would be taking care of people we now take care of for nothing.

But as individual physicians, to us and our generation, it would make very little difference if we think only in terms of economics; if we think

LET'S TELL THE TRUTH

Continued

only in terms of how long we're going to live. But if we think in terms of the noble heritage not only of our nation but of our profession, made noble not by virtue of our own efforts but by virtue of the great men and women who went ahead of us, then we, too, have a responsibility to our children and those who come behind us.

As Dr. Judd says, this world conflict is not an old-fashioned struggle for control of land, it's for the control of man, the mind of man, the soul of man, the whole of man. It is total conflict. No one has the right to ignore it, no one dares



Senator Vance Hartke (right) entertained members of the Executive Committee during their annual visit to Washington, D. C., in May.

fail to play his full part in this conflict, as a physician, as a citizen, as a free human being. ◀

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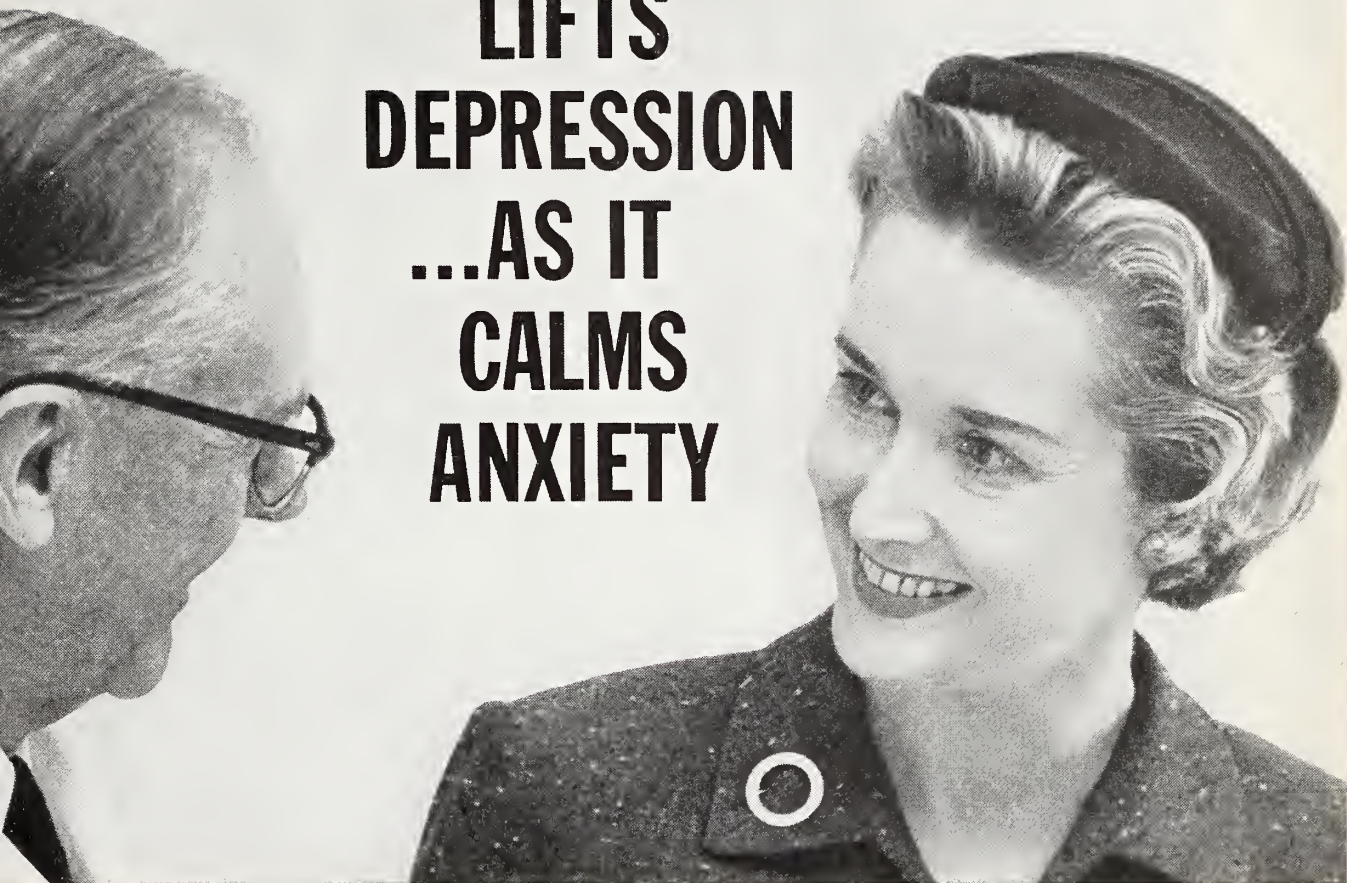
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Medicine

At

Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Physician Held Not Negligent for Emergency Treatment—The decedent was in an automobile accident. He was taken by ambulance to the Pittsburgh Community Hospital. The defendant, a general practitioner, was on emergency call at the hospital. He arrived at the hospital shortly after the decedent arrived. The physician examined the decedent's head wound and applied a pressure bandage to it. He was unable to suture the wound because of decedent's movements. The bleeding was satisfactorily taken care of. The doctor suspected a head injury. No x-rays were taken, the doctor's experience being that the neurosurgeon would want to direct the taking of x-rays. The doctor concluded that it was important to get the decedent to such a specialist. He felt that a neurosurgeon was more readily available at the Kaiser Hospital in Walnut Creek. Accordingly, he ordered the decedent taken to the Kaiser Hospital in an ambulance. He gave no instructions as to treatment to the ambulance men, having confidence in them from prior experience. He did not phone the hospital or decedent's home, or have anyone else do so because he had confidence in the set-up at the Kaiser Hospital and relied on it. He did not believe that the patient was in danger of death. But the decedent was dead on arrival at the Kaiser Hospital.

The judgment for the physician was affirmed by the District Court of Appeals. The court also held the doctrine of *res ipsa loquitur* inapplicable.

But the court was highly critical of the care rendered by the physician. The court stated:

"To us, as laymen, the handling of decedent is shocking, even though it may not have caused the death in this particular case. Nothing was done to determine whether in fact a neurosurgeon might be promptly available at the Pittsburgh Hospital, where the decedent was entitled to such treatment. Nothing was done, before he was shipped off, unattended by any qualified nurse or doctor, and with no instructions to the ambulance crew, to determine whether a neurosurgeon was anymore readily available at Walnut Creek. In fact, a neurosurgeon was not so available there. The hospital there was not alerted. No attempt was made to communicate with decedent's wife."—*Black v. Caruso*, 9 Cal. Rptr. 634 (Calif., Dec. 8, 1960).

City Hospital's Governmental Immunity Not Adversely Affected If It Has Liability Insurance—The plaintiff was operated upon in the defendant hospital by a staff surgeon. A sponge was left in the plaintiff's abdominal cavity and a second operation was required to remove it. The plaintiff sued both the surgeon and the hospital. The case against the surgeon was settled.

The hospital was owned and operated by the City of Pontiac in Michigan. It is the law of Michigan that a municipality is not liable for negligence in the performance of such a function. The court held that even though the City of Pontiac carried insurance indemnifying it against liability, such as was alleged in this case, the city was not prevented from invoking its govern-



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MEDICINE AT LAW

Continued

mental immunity.—*Harrison v. City of Pontiac, Mich.*, 285 F. 2d 305 (C. A. 6, Jan. 18, 1961).

Malpractice Judgment Reduced—A judgment of \$114,600 was awarded to the plaintiff in a malpractice action. On appeal the New York Appellate Court held this verdict to be grossly excessive. The court ruled the judgment would be vacated and a new trial granted unless the defendant waived its lien on the plaintiff's recovery for hospital charges in the amount of \$28,000 and the plaintiff stipulated to accept \$60,000 in lieu of the amount awarded by the jury.

The court stated that the jury could have found negligence "in diagnosis, treatment of the arm fracture, and treatment of decubiti." But the court acknowledged that the "plaintiff was not sufficiently cooperative, and this failure critically frustrated treatment of decubiti and other conditions from which plaintiff suffered."—*McCrain v. City of New York*, 207 N.Y.S. 2d 685 (N.Y., Nov. 29, 1960).

Hospital Record of Unrelated Subsequent Treatment Properly Excluded in Malpractice Suit—The Connecticut Supreme Court has upheld a defendant-physician's objection to including a specific entry on a hospital record as evidence in a malpractice suit. The physician had performed a bilateral removal of a recurrent nodular goiter in 1955 on the plaintiff. She charged negligence, alleging her right vocal cord was paralyzed during the operation. She was admitted to the same hospital in 1957 for an incomplete abortion. During the course of the trial of the malpractice suit, she sought to have hospital records on her 1957 admission introduced as evidence. The record mentioned the earlier throat operation and contained the following statement: "Probable paralysis of the right recurrent laryngeal nerve." The trial court granted a request to exclude this particular entry. On appeal the Supreme Court said there was no error in excluding the entry since the 1957 hospitalization was in no way related to the 1955 operation.—*Maggi v. Mendillo*, 165 A. 2d 603 (Conn., Nov. 8, 1960).

Judgment Awarded for Death Caused by Transfusion of Wrong Type of Blood—On February 17, 1961 a Navy officer was awarded \$15,000 in damages for the death of his wife by a U. S. District Court judge, who heard the case without a jury. She died after being given the wrong type of blood after pelvic surgery and a caesarean section at the Key West Naval Hospital.—*Legare v. The United States*, United States District Court, Jacksonville, Florida (Feb. 17, 1961).

Judgment Rendered Against Hospital to Patient Who Fell Out of Bed—An 80-year-old woman was admitted to the defendant hospital for severe constipation. On her second day in the hospital she fell from her bed fracturing a hip. She alleged negligence on the part of the hospital because of the failure to put up bed rails on more than the upper third of her bed. She also charged the hospital with negligence in connection with the development of severe bed sores during her two months' stay in the hospital. The jury awarded the plaintiff \$7,500 in damages.—*Siergiej v. St. Anthony De Padua Hospital*, 60 C-4637 Superior Court, Chicago, Ill. (Mar. 3, 1961). ◀



"What do you like the best . . . stomach acid putting the hole in the handkerchief or the guy dissolving fat globules?"

Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.

Indianapolis

Lactic Dehydrogenase and Coronary Occlusion

Another paper adding to the evidence of reliability and usefulness of the lactic dehydrogenase test is presented by King and Waind¹ in their study of 32 patients with evidence of myocardial infarction. Serum GO-Transaminase and lactic dehydrogenase determinations were done, and the results were compared. There were no false positives in the LDH tests, and only two false negatives, one of which was admitted a number of days after the occlusion took place. As in other reports, LDH remained elevated a number of days after SGO-T had returned to normal. Duration of elevation was about 10 days. The authors say that LDH determinations are simpler to carry out than SGO-T, and are time-saving. The test is known not to be specific for coronary occlusion, because it has also shown to be elevated in carcinoma, leukemia and certain forms of anemia, and also in pulmonary embolism (in which case the SGO-T would not be elevated). However, the authors believe that it is a very useful test, and very accurate, if used within these limitations.

Accident Liability and Menses

A statistical study was done by Dalton to relate accidents involving women to their menstrual cycles, in 84 menstruating females involved in accidents.² Her study shows that more than half of the accidents occurred during menstruation or in the four days preceding the menses. The probability of this occurring by chance is said to be less than one in 1,000. She concludes that this indicates that menstruation is a significant factor in accident-proneness. Previous studies by the author showed that schoolgirls'

work was poorer during menstruation and that disciplinary measures were needed more at such times with students. Another speculation is that perhaps it is unwise to use tranquilizing drugs for treatment of premenstrual tension which might make these females even more accident-prone by further depression of already impaired judgment.

To Obtain a Urine Culture

In a paper which concludes with a plea to abandon routine catheterization of females to collect urine specimens for culture, Clarke³ compared urine from both sexes by cleaned, mid-stream voided specimens and catheterized specimens for culture. He found 74% of male specimens to be satisfactory, and 72% of female specimens to be satisfactory. These figures compared with 93% and 85% for catheterized specimens, respectively. The study included 342 specimens. While there is a higher percentage of accuracy with catheterized specimens, the author does not feel that this is high enough to warrant use of catheterization routinely because the danger of introducing bacteria into the urinary tract outweighs the increase in accuracy. Another plea is for prompt culture of specimens because the percentage of satisfactory specimens in all groups dropped significantly when there was a delay of even one day in culturing the specimen.

Radioiodine and Leukemia

A restrained, optimistic report is presented by Pochin⁴ concerning the incidence of leukemia in patients receiving radioiodine for thyrotoxicosis. This was a statistical study involving letters to contact all physicians or hospitals in the United Kingdom who had used radioiodine for this pur-

ABSTRACTS

BOOK REVIEWS

REVIEW OF MEDICAL MICROBIOLOGY

Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D., 377 pages with illustrations. Lange Medical Publications, Los Altos, Calif., 1960. \$5.00.

This review, as the author's preface states, is intended primarily for the medical student or practicing physician. The book fulfills adequately this intent. A considerable portion of material is devoted to brief resumés of various facets of basic science. The subject matter is well selected and presented in an orderly and intelligible manner.

It does seem that the section on mycology has been too briefly treated, as is the unfortunate circumstance in too many hospital laboratories.

Material is presented by simple statement of fact and as such seems at times to generalize too broadly. In addition, these statements do not contain annotated references which I believe seriously lessens the overall value of such a review. With these objections in mind and

GLEAINED

Continued

pose to ascertain how many patients had subsequently developed leukemia, for comparison against the number of cases of leukemia that could statistically be expected to appear spontaneously in a population of that size. One striking feature of this study is that there were replies from all inquiries to physicians and institutions. Approximately 21 cases (range from 14 to 28) were expected to appear in such a group by statistical prediction, and only 18 cases were documented as having leukemia in the treated group. More time will be needed to confirm or change these figures, and certainly there are numerous difficulties in follow-up over a 20-year period such as this. At least, the preliminary report is encouraging.

REFERENCES

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2. Dalton, K.: Menstruation and Accidents. *Brit. Med. J.* 5210: p. 1425, 1960.
3. Clarke, S. H. C.: Investigation into Methods of Collection of Urine for Culture from Men and Women. *Brit. Med. J.* 5211: p. 1491, 1960.
4. Pochin, E. E.: Leukemia Following Radioiodine Treatment of Thyrotoxicosis. *Brit. Med. J.* 5212: p. 1545, 1960. ◀

more thorough reference books at hand this review can be recommended as a quick and ready source of information.

William Beheler, M.Sc.
Microbiologist
Ball Memorial Hospital
Muncie

MEDICINE TODAY

Marguerite Clark, Funk & Wagnalls, N. Y., \$4.95, 358 pages.

Mrs. Clark has done her homework well, and has the skill to make herself understood easily and pleasantly. As medical editor of *Newsweek*, she has had a weekly deadline to meet; she has to be succinct, absolutely correct and completely understandable to the lowest common denominator of her reading public.

These skills are not easily come by; they require long training and development. I found myself reading her book with its many and varying chapters with ever-increasing pleasure. It is truly amazing to see a lay person grasp so well many rather complex medical concepts. It is an unalloyed pleasure to see her presenting these ideas in words interesting to the doctor and comprehensible to the lay reader.

There are very few errors in the text. On page 317, I was intrigued by the statement that in 1668 the Merck firm was founded by F. J. Merck and that his son, Geo. Merck, in 1891, established the business in Rathway, N. J. Such typographical errors in no way detract from the readability of the book. It is highly instructive and can be recommended as reading for both the doctor and his patients.

Arnold Lieberman
New York, N. Y.

EPIDEMIC

Frank G. Slaughter, Doubleday, New York, 286 pages, \$3.95.

The jacket is lurid and the promotional blurb sensational—still, this tale is not up to Dr. Slaughter's standards. The story is basically interesting enough: what were to happen in N. Y. were an epidemic of bubonic plague to get going.

Of course, the medical details are exact and the descriptive details meticulously correct as far as they go. Still, the author takes 286 pages to narrate a plot that is tenuous at best. The magazine, *MD*, in its July 1960 issue carried in its Public Health section a three-page succinct summary (with illustrations) of the entire topic.

The lay reader might find unpalatable the descriptions in *Epidemic* of the rats, brown and black, the fleas, particularly the *Xenopsylla cheopis* that regurgitates into its victim the actual agent of the dread plague, *Pasteurella pestis*, and the two forms the disease takes in the clinical manifestations, i.e., the bubonic and the pneumonic.

The *MD* article tells it all more clearly and pithily without annoying the reader with vague villains and misty heroines. Bluntly, this concoction is, in my opinion, a mere potboiler not worth the stated price.

Arnold Lieberman
New York, N. Y.

COMMUNICABLE AND INFECTIOUS DISEASES

Franklin H. Top and 22 collaborators; 4th ed.; 15 plates, 122 figures, 28 tables; C. V. Mosby Co., 1960, 812 pp., \$20.00.

This completely revised 4th edition of an established classic brings up to date the discussion of even such presently controversial topics as the use of live poliomyelitis oral vaccine.

The individual chapters are most commendably brief, authoritative and intensely practical; the various contributors balance nicely between giving a mere outline and betwixt being unduly verbose.

The plates are so incomparably better than the black and white figures that I can only make a humble plea for more—and still more—color!

The format has been improved and standardized for easy reference, clear instruction and quick answers to the questions that had sent the reader to this text in the first place. The tables and the concise text aid greatly in this worthy endeavor.

The publisher has continued to use splendid paper, clear text and high quality binding.

Dr. Top and his able corps of collaborators are to be congratulated for such a continually distinguished performance. Every hospital library will want to have this new edition on its shelves. Most doctors in private practice should continue to be aware of this book; certainly, many will want to have it on their own shelves for the sake of a rapid, refreshing, look-see.

Arnold Lieberman, M.D.
New York, N. Y.

THE HEINZ HANDBOOK OF NUTRITION

B. T. Burton, Ph.D., executive editor; 439 pages, 34 numbered tables, profusion of sample menus, tables of food composition, etc. McGraw-Hill, N. Y., 1960, \$5.75.

Aided by a distinguished editorial board, Dr. Burton has managed to weld together an enormous mass of material that has something for the erudite scholar as well as pabulum for the freshman student of home economics.

Within the covers of this unpretentious manual, we have the essence of an authoritative textbook and reference handwork; sheer volume has not been confused with a crisp, clear presentation of essential data.

Every practicing physician will find this an intensely practical, useful volume containing immediate answers to the questions perplexing both the patient and the doctor. The printing is clear, the paper is excellent and the binding has firm heft.

For my part, I liked tremendously the first two parts in which the utilization of foods and the food elements are presented completely and concisely. Part 3 on "Nutrition in Health" covers an enormous range with delightful briskness; Part 4 on "Nutrition in Disease" ranges the entire field at the same incisive, even, clear pace.

Errors are few and will be deleted by the next edition, I'm sure. They are picayunish trifles and in no way detract from a splendid achievement.

The H. J. Heinz Company is to be congratulated for

having the "selfishness" to place such a volume within the reach of the medical profession.

Arnold Lieberman, M.D.
New York, N. Y.

PREVENTIVE MEDICINE IN WORLD WAR II, VOLUME V

In a fighting Army, even the mildest diseases can cause a steady erosion of manpower. The Army Medical Services' achievements in conquering the diseases that felled the fighting forces of World War II is the subject of a new book, *Preventive Medicine in World War II, Volume V*. Published about June 15, this sixteenth volume of the series, *Medical Department, U. S. Army, in World War II*, is devoted to communicable diseases "transmitted through contact or by unknown means."

Success of the Army's program for the prevention and control of disease is indicated by the remarkable decline in the ratio of deaths from disease to deaths from combat injuries. For every soldier killed in combat in the Spanish-American War, five died from disease; in World War I, one man succumbed to injuries for every one who became the victim of disease; and by World War II, the ratio had dropped to .07 to one.

In this new volume, the second of three to deal with communicable diseases, nearly 200 pages are devoted to the prevention and control of venereal diseases, with considerable emphasis upon the social problems encountered in the various theaters of war.

Continued

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ABSTRACTS, REVIEWS

Continued

Other diseases covered include epidemic keratoconjunctivitis, hookworm, schistosomiasis, skin infections, trachoma, infectious mononucleosis, viral hepatitis, and a number of others not as frequently encountered.

Among the many eminent medical men who have contributed to this volume are Dr. Thomas B. Turner, Dean of the Medical Faculty and Professor of Microbiology at The Johns Hopkins University; Dr. Thomas G. Ward, Professor of Virology at the University of Notre Dame; and Dr. James A. Doull, Medical Director of the Leonard Wood Memorial and formerly Medical Director of the U. S. Public Health Service.

This book provides excellent reference material for medical students, physicians, epidemiologists, immunologists, venereal disease control officers, entomologists, parasitologists, malariologists, health officers and nurses and sanitarians.

It may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for \$6.00.

U. S. Army Medical Service

Abstracts From Various Literature, Prepared by AMA

REVERSIBILITY OF ATHEROSCLEROSIS

Taylor, C. B., Cox, G. E., Trueheart, R. E.: Reversibility of Atherosclerosis. *Ill. Med. J.* 119:80, Feb., 1961.

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October 16
Surgical Board Review, Part I, Two Weeks, November 6
Surgical Board Review, Part II, Two Weeks,
November 27
General Surgery, One Week, September 18
Hand Surgery, One Week, October 9
Gynecology, Office & Operative, Two Weeks,
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Vaginal Approach to Pelvic Surgery, One Week,
September 11
Obstetrics, General & Surgical, Two Weeks, October 9
Basic Electrocardiography, One Week, October 2
Basic Internal Medicine, Two Weeks, October 16
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Thoracic Surgery, One Week, October 16
Blood Vessel Surgery, One Week, November 13
Urology, Two Weeks, October 23

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The authors reject the concept that atherosclerosis is not reversible, pointing out that the pioneers in atherosclerosis demonstrated its reversibility, and that pathologists encounter indirect evidence at the autopsy table indicating that atherosclerosis undergoes regressive changes. Experimental and clinical evidence indicates that lipids move into arterial tissue when serum cholesterol levels are above 250 mg per 100 cc.; lipids are apparently resorbed from arterial tissue when serum cholesterol levels are below about 200 mg per 100 cc. Cholesterol plaques should be thought of as resorbable "foreign" material just as one expects resorption of foreign materials from subcutaneous bruises, hematomas, traumatic subcutaneous fat necrosis, or peanut oil as a vehicle for an injectable drug.

PRENATAL INFECTION WITH VACCINIA VIRUS

Wielenga, G., van Tongeren, H. A. E., Ferguson, A. H., van Rijssel, Th. G.: Prenatal Infection with Vaccinia Virus. *Lancet* (London), 1:258, Feb. 4, 1961.

An intra-uterine infection with vaccinia virus in a 27½-week-old fetus is described. The virus was isolated from the skin and the placenta. The nonvaccinated mother must have been infected by her first-born child, who was vaccinated when the mother was 18 weeks pregnant—18 days after this the mother had complained of a sore throat with fever. In this period, therefore, the mother had been exposed to a direct source of vaccinia infection, and she showed symptoms which could be caused by airborne infection with the virus. The mother had no skin eruptions, although antibodies against vaccinia virus were demonstrated in her blood. The macroscopic and microscopic findings in the fetus, the placenta, and the membranes are described.

PHYSIOLOGIC TREATMENT OF HEAT STROKE

Hoagland, R. J., Bishop, R. H., Jr.: Physiologic Treatment of Heat Stroke. *Am. J. Med. Sci.* 241, April, 1961.

Phenothiazine's metabolic dampening and "neuroplegic" actions provided pharmacologic, instead of the conventional physical, means of treating heat stroke. They can produce hypothermia without the use of cold water; they can prevent the death of animals from experimentally produced shock and from hyperthermia itself. Dipyrone and related drugs reduce body temperature by central action. Therefore, chlorpromazine and dipyrone were used to treat heat stroke. No ice or cold water was used. Other treatment used was: hydrocortisone and oxygen (intermittent positive pressure) for the first two hours. The patient presented had a body temperature in excess of 108.6° F. (42.5° C.), was comatose, and had no measurable diastolic blood pressure before treatment. One and one-quarter hours after the first injection of chlorpromazine and dipyrone (Novaldin) the diastolic pressure was 70 mm Hg. Two hours after the first injection, the patient was fully conscious. The total dose used was: phenothiazine, 250.0 mg and dipyrone, 1.0 gm.

Blue Shield is the instrument of the lower and better qualified group, namely the medical profession. Individual members of the profession must be reminded of the continued integrity of purpose of Blue Shield. More of them must be brought into participation at an active level through committee membership and service on advisory groups. We must not forget that Blue Shield represents the entire profession, and must not let itself be led by the efforts of organized minorities into actions which are favorable only to those minorities. Those changes in Blue Shield programs which are acceptable to the profession as a whole and which meet the public need, must be enthusiastically embraced. Those which would benefit a segment of the profession only must be avoided with equal enthusiasm.

To this end closer liaison with organized medicine at the local level is essential. Communications between state and county medical organizations and their component Blue Shield plans must be increased. We must realize that Blue Shield inevitably will influence, at least on the economic side, the practice of medicine and the patient-

doctor relationship. We must insure, through consultation with organized medicine and thoughtful consideration on the part of Blue Shield governing boards, that these influences will not adversely affect the art and science of medical practice.

It is to the everlasting credit of the medical profession that Blue Shield was created. The scientific senses of medicine have become so acute and so constantly used that little time is left for the development of economic senses. Blue Shield must serve as eyes to see the danger arising from a vocal minority of the profession who would maintain the status quo in the face of economic change. It must be the ears to hear the murmurs of public demand before they become a roar. It must be the tongue to savor the sweet and sour of economic change before a bite is swallowed. It must be the nose to detect the aroma of the social planners and bureaucrats who would, for selfish interests, deposit their offensive socialistic excrement on public and profession alike. Blue Shield must be the touch kept gently and reassuringly on the public wrist alerting the profession to impending crises. ◀

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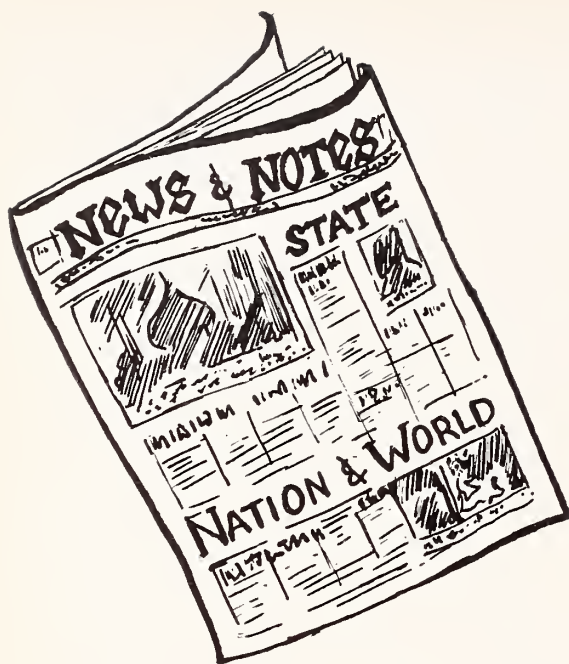
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Many Hoosiers Take Part in AMA New York Meeting

Indiana was represented officially at the meetings of the AMA House of Delegates during the recent meeting in New York City by Drs. E. S. Jones, Hammond; Francis L. Land, Fort Wayne; Harold C. Ochsner, Indianapolis; Wendell C. Stover, Boonville and Gordon B. Wilder, Anderson. In addition to these Dr. Lester Bibler, Indianapolis, was delegate for the Section on General Practice and Dr. Lall Montgomery, Muncie, delegate for the Section on Pathology and Physiology. Dr. Stover served on the Reference Committee on Reports of the Board of Trustees.

Membership on the Councils of the AMA included Dr. Don Wood, Indianapolis, the Council on Legislative Activities, Dr. E. S. Jones, Hammond, the Council on Occupational Health and Dr. J. B. Hickam, Indianapolis, on the Council on Scientific Assembly.

In the scientific program, Dr. Charles R. Alvey, Muncie, served as chairman of the Section on General Practice and Dr. Harris B. Shumacker, Jr., Indianapolis, was chairman of

the Section on General Surgery. Dr. Myron Nourse, Indianapolis, was Assistant Secretary of the Section on Urology.

Dr. John A. Campbell, Indianapolis, was on a panel which discussed "Prenatal Influences on the Newborn" before a joint meeting of the sections on Obstetrics and Gynecology and Pediatrics. Dr. Harris B. Shumacker, Jr., of Indianapolis was moderator of a Symposium on Polypoid Disease of the Colon which was presented before a joint meeting of the sections on Gastroenterology and Proctology, Preventive Medicine, Radiology and General Surgery.

Dr. Henry G. Nester of Indianapolis, read a paper before the Section on Preventive Medicine on the subject "The Need for Improvement of Undergraduate Instruction in Public Health in Medical Schools."

Dr. Robert H. Denham, Jr., South Bend, served as demonstrator of an exhibit on fractures. Dr. John B. Hickam, Indianapolis, was a sponsor of an exhibit on Pulmonary Function.

Dr. William D. Snively, Jr., Evansville, was a

participant and chairman of the committee for a Special Exhibit and Clinical Forum on Body Fluid Disturbances.

Drs. C. A. Bonsett, B. E. Abreu and J. D. Ralston of Indianapolis sponsored an exhibit on Studies on Muscle Disease by Means of an Electrophoretic Myotome for the Section on Nervous and Mental Diseases. Dr. Lall Montgomery, Muncie, presented an exhibit on Certification of Medical Technologists for the Section on Pathology and Physiology. Drs. F. B. Peck, Jr., and C. N. Christensen, Indianapolis, presented an exhibit on Rabies—Postexposure Immunization for the Section on Preventive Medicine.

Three Hoosier Doctors Certified By OB-Gyn Board

Three Indiana physicians were recently examined and certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. They include Drs. Virgil R. Graber, Elkhart; Charles Roscoe Mather, Lafayette; and Ramona Jean Middleton, Elkhart.

ARTIFICIAL LIMB WEARERS

Hanger Limbs are being successfully worn by amputees of all ages.

David Confield, just 13 months (illustrated), is one

of the many young children growing up on Hanger Legs. In contrast, Captain W. T. Traylor, over 75 (illustrated), now wears his fifth Hanger. He is a fire inspector who must cover continually hospitals, schools, sports events, etc., and be on his feet for hours at a time.

The success of Hanger Limbs with amputees of such widely varying types can be largely attributed to custom

manufacture and individual fitting. Unusual conditions are carefully investigated by experienced fitters, and limbs are manufactured to meet individual requirements. The experience of Hanger's over 100 years is given to every amputee so that his rehabilitation may be successful.

Age: 13 Months



Age: 78 Years



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418 N. Main St., Evansville, Ind.

Atomic Energy Commission Grants Awarded to Five Hoosier Schools

The U. S. Atomic Energy Commission recently announced the award of 175 grants to 165 educational institutions for the purchase of laboratory equipment to initiate or expand curricula in either life sciences or in physical sciences and engineering. The grants for this year total \$1,950,797. The totals for the five years that the program has been in effect are 427 institutions and \$20,358,689.

In addition the Commission has loaned approximately \$11,000,000 worth of nuclear materials to many of these institutions. Grants to Indiana institutions included Indiana University, \$13,117; University of Notre Dame, \$22,528; Rose Polytechnic Institute, \$9,571; Valparaiso University, \$4,610 and Wabash College, \$7,160.

DR. MUMFORD HONORED

Dr. E. Bishop Mumford, well-known Indianapolis orthopedic physician, has been cited for his contributions of service to Marion County General Hospital.

The hospital's orthopedic staff presented a plaque designating the E. Bishop Mumford Orthopedic Clinic in the outpatient department of the hospital. A reproduction of an oil painting of Dr. Mumford, also in the clinic, was presented to the hospital by the Indiana Bone and Joint Society.

Dr. Hodes Receives Leukemia Grant For Five Years' Research

Dr. Marion E. Hodes, Assistant Professor of Medicine and Biochemistry, Indiana University School of Medicine, has been selected by the Leukemia Society as a grantee for a period of five years under the Society's new Scholar Program.

Designed to aid career investigators, the program provides salary grants of from \$10,000 to \$15,000 for a period of five years and possibly ten years. The scientist is thus assured an opportunity for continuity of work and time enough to complete long-range projects. Dr. Hodes will continue his teaching work at Indianapolis and also participate in research.

Continued

The two college youths had just enjoyed a large fruit cake from home, when one began to groan, doubling himself up and straightening out again.

"What's the matter, Jack?" asked his friend. The sufferer groaned.

"That cake I ate . . . I think my mother forgot to shell the nuts in it." His companion looked surprised.

"Gosh," he said, "and can you crack 'em just by bending?"—Quote, Vol. 41, No. 11, 1961.

NEWS NOTES

Continued

Michigan's New Look . . .



Members of the Michigan State Medical Society dedicated this new headquarters building in East Lansing, Mich., at ceremonies June 4. Designed by the internationally-famous architect, Minoru Yamasake, Birmingham, the two-story functional building contains approximately 20,000 square feet of floor space. Distinguishing feature of the structure is the white vaulted roof of pre-cast concrete. Semi-circular roof vaults are held up by tall columns of precast quartz aggregate surface concrete, and much of the exterior wall is glass.

DR. RADER NAMED PRESIDENT OF NEUROPSYCHIATRIC ASSOCIATION

Dr. George Rader, Indianapolis, is the newly-elected president of the Indiana Neuropsychiatric Association. Also elected at a May 17 meeting in Indianapolis were Drs. Marvin Greiber, Muncie, president-elect for the district branch; Paul Merrell, Indianapolis, president-elect for I.N.P.A.; Dwight Schuster, Indianapolis, vice president; and Gordon Brown, Indianapolis, secretary-treasurer.

Members of the Board of Directors will be Drs. Eldred Hardtke, Bloomington; and Donald Moore and John Southworth, both of Indianapolis; Dr. Earl Mericle, Indianapolis, is delegate to the assembly of district branches; Dr. Ernest Fogel, Logansport, will serve as his alternate.

Dr. Annis Joins Medical Economics Staff

Dr. Edward R. Annis, Miami, Fla., well-known for his debating ability and for his articulate opposition to the socialized practice of medicine has accepted an appointment as Editor-at-Large of *Medical Economics*. He is scheduled to write a biweekly column. He will also continue his extensive commitments on the speaking circuit.

New Film Clarifies M.D.'s Role In Social Security Disability

A 30-minute motion picture film is now available to acquaint physicians with the administrative processes involved in establishing disability for social security purposes. The picture is titled "The Disability Decision" and was made by the Social Security Administration in cooperation with the American Medical Association. It is intended to clarify the doctor's role in the social security disability program and outlines the kind and extent of medical information the physician is asked to provide.

Prints of the film may be obtained by addressing Mr. McKillen at the Indianapolis Social Security office, by calling Melrose 2-1581 in Indianapolis or by writing to the Film Library of the AMA.

OB-Gyn College Re-elects Hoosier; Announces Regional Conference Plans

Dr. Nicholson J. Eastman, Baltimore, Md., was inducted as president of the American College of Obstetricians and Gynecologists at a recent tenth anniversary meeting in Bal Harbour, Fla. Dr. Sprague Gardiner of Indianapolis was re-elected as assistant secretary.

The College announced a series of regional conferences on obstetric, gynecologic and neonatal nursing. The meeting for this region will be held in Louisville on Nov. 16-18, 1961. Chicago was announced as the site of the 1962 annual meeting.

Dr. Bechtol Rejoins Baxter Labs

Dr. Lavon D. Bechtol has rejoined Baxter Laboratories, Morton Grove, Ill., as director of clinical research. At one time he served as associate medical director of Baxter. He has also been medical director of Ethicon, and was a research pharmacologist with Lilly Research Laboratories. He holds an A.B. degree from Manchester College, a Ph.D. from Purdue University and the M.D. degree from Johns Hopkins.

William C. Luther, M.D. has been appointed to the post of Assistant Medical Director of Ames Company, Elkhart, Ind. Dr. Luther has been a member of Ames medical staff for the past 12 months. Prior to that he practiced medicine in Sullivan, Maine.

Allen County Selected as Sample For U. S. Health Examination Survey

Allen County, Indiana, will be visited by the Public Health Service's Health Examination Survey during a two and a half week period beginning July 19.

Allen County has already contributed to this national project. In the spring of 1959 it was the scene of one of the three pretests conducted prior to the start of the actual Survey. On that occasion the generous cooperation of the medical professions and the public made the experience most useful to the Survey in developing its special health examination and solving the logistical problems inherent in taking the examination to sample localities throughout the country.

In the July examinations, Fort Wayne and its environs will now provide actual data.

Sample Includes 150 Adults

About 150 adults will be examined. They will not be volunteers, but persons preselected by a probability sampling technic. In effect, the people to be examined are chosen at random from the whole population of the county—irrespective of their social, economic, or health characteristics.

Examinations will be performed in the Health Survey's mobile examination center, brought to the area and set up in a convenient location.

Purpose of the examinations is to collect, on a uniform basis, statistical information on certain chronic conditions, particularly cardiovascular diseases and arthritis, and on physical and physiological measurements. The health examination is conducted in a single visit. It consists of a medical history; a physical examination for certain conditions for which examination can be made in a uniform way and in a single visit; and for which diagnostic criteria exist; a dental examination; screening tests for visual acuity and hearing; a 12-lead electrocardiogram; blood pressure determinations; 6 foot-14x17 chest x-ray; x-rays of hands and feet; modified glucose tolerance test; microhematocrit determination; serologic test for syphilis; serum cholesterol level; serum bentonite flocculation test; urine sugar (and albumin for males); height and weight; and a series of body measurements which are important—from the standpoint of safety

and efficiency—in the design of motor vehicles, aircraft, and farm and industrial machinery.

Findings are not disclosed to examinees directly. Each individual is asked, however, if he wishes the findings supplied to his own dentist and physician; and if the examinee so authorizes, a report is sent to the physician and dentist he designates.

Not a Substitute

The health examination is not intended as a screening procedure; referral for diagnosis is not made. The fact that the examination is not complete and is not a substitute for a visit to one's own physician and dentist is stressed with each examinee.

Examining physicians will be fellows or senior residents in internal medicine working temporarily with the Public Health Service. Other team members are nurses, a dentist, x-ray technicians, and history-interviewer receptionists regularly on the PHS staff.

The Health Examination Survey is a major project of the U. S. National Health Survey authorized by Congress in 1956. It constitutes the first attempt in this or any other country to perform examinations on a representative sample of the national population.

The Allen County "stand" will be the sixteenth in the national sample. The data gathered in the survey will not produce separate figures for localities or states. When all the "stands" are completed, the results will yield estimates for the United States as a whole.

Another part of the National Health Survey program—a Health Interview Survey which has been going on since July 1957—has already produced reports on topics which can be investigated appropriately by this technic. Among the topics published so far are physician visits, dental care, disability, persons injured, acute illnesses, hospitalization, impairments, and broad groupings of chronic conditions.

Summary statement prepared by U.S. Dept. of Health, Education and Welfare.

Continued

NEWS NOTES

Continued

October Cancer Society Session To Emphasize Total Care

The 1961 Scientific Session of the American Cancer Society will be held at the Biltmore Hotel, New York City, on October 23 and 24, 1961. The main topic will be "The Physician and the Total Care of the Cancer Patient." Discussion will be developed by 5 panels of experts with subjects as follows: Decisions in the Early Care of the Cancer Patient, Counseling the Cancer Patient, What the Cancer Patient Should be Told About His Diagnosis and Prognosis, Care of the Advanced Cancer Patient, and Society's Role in Caring for the Cancer Patient.

Editor Elected to Advertising Committee

Dr. Frank B. Ramsey, editor of the *Journal*, has been unanimously elected to membership on the Advisory Committee of the State Journal Advertising Bureau, Inc., Chicago, publisher's advertising representative for the *Journal*. He began a five-year term by attending a June session of the group.

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HENRY A. DOLLEA, M.D., Superintendent

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Two I.U. Students Winners in ASMA Exhibit Competition

Two students of Indiana University School of Medicine won Lakeside Awards for their scientific exhibits at the Annual Student American Medical Association convention in Chicago. Byron L. Annis received \$250 and a certificate for his exhibit, "The Mechanism of Action of Some Skeletal Muscle Relaxants." Harold R. Novotny received an honorable mention for an exhibit on "A Method of Photographing Fluorescence in Circulating Blood of the Human Retina." Lakeside Laboratories, Milwaukee, sponsors the awards.

SKF Foundation Grants Total \$592,485

The Smith Kline and French Foundation in a recent report announced grants during 1960 totaling \$592,485 to nearly 300 agencies in the United States. The Foundation was established in 1952 and supports four major areas—education, mental health, public charities and community improvement and specific research projects.

New Albany Youth Recognized in Science Fair Medical Category

Harvey Scribner III, 18, New Albany, won a certificate of merit in the pathology-medical technology award list for his exhibit on "effects of radio waves on cancer" in the National Science Fair held in Kansas City May 10-13.

Special awards in the pathology-medical technology category were given for the first time this year. Sponsors included the Armed Forces Institute of Pathology, American Society of Clinical Pathologists, American Society of Medical Technologists and the College of American Pathologists.

PAMPHLET ON CATARACT, GLAUCOMA AVAILABLE FOR LAY READERS

"Cataract and Glaucoma—Hope Through Research" is the title of a public information pamphlet recently released by the Public Health Service. The 16-page booklet is written for lay readers. It discusses the two diseases from the standpoint of eye changes, symptoms, proper treatment and improper treatment. Single copies may be obtained without charge. Orders under 100 are 15 cents a copy. There is a 25% discount on orders of 100 or more. For sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C. ◀

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1961 annual meeting of the Indiana State Medical Association, Oct. 24-26, in Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces which they have produced should fill in the form given below and mail it to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple, Indianapolis. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name _____

Address _____ City _____

Type and number of pieces to be displayed: Photography _____

Sculpture _____ Crafts _____

Painting _____ Other _____

Estimated amount of space required—lineal or square feet _____

Other information _____

Deaths

James Francis Clancy, M.D.

Dr. James Francis Clancy, Hammond pediatrician, passed away May 11 at the age of 61.

A graduate of the University of Michigan, class of 1925, Dr. Clancy formerly served on the ISMA Committee on Lye Burns in Children.

Dr. Clancy served during 1942-43 in the Army Medical Corps at Station Hospital, Abilene, Texas.

David Hayden Richards, M.D.

Dr. David H. Richards, 90, who retired seven years ago after practicing for over 50 years, most of them in Vincennes, passed away May 9.

Well known as an ENT specialist, Dr. Richards was instructor in head diseases at Good Samaritan Hospital School of Nursing for 34 years.

Dr. Richards was a graduate of the I. U. School of Medicine; prior to entering medical school he taught school for six years.

Kenneth E. Thornburg, M.D.

A well-known Indianapolis internist, Dr. Kenneth E. Thornburg, passed away suddenly May 15 in his home. He was 55.

A graduate of DePauw University and Indiana University School of Medicine, class of 1933, Dr. Thornburg was a member of Methodist, St. Vincent's and Community hospital staffs in Indianapolis. He was former chief resident at Methodist.

In ISMA, Dr. Thornburg served as delegate from Marion County in 1954.

Russell William Wood, M.D.

Dr. Russell W. Wood, physician and surgeon of Oakland City for 24 years, passed away April 30 in Evansville. He was 54.

Dr. Wood had operated the Wood Clinic, forerunner of Oakland City Hospital, for six years. He was also on the staff of the Gibson General Hospital at Princeton.

Dr. Wood was a Naval lieutenant commander and served in the Pacific Theater during World War II.

Tim Sullivan, Food & Drug Head

T. E. "Tim" Sullivan, Director of the Food and Drugs Division of the State Board of Health, died June 1 of cancer in an Indianapolis hospital. He was 60.

Mr. Sullivan was recently selected by the State Department to go to Formosa for the purpose of suggesting improvements in that nation's food and drug program. Physical examinations made in preparation for that trip indicated the fatal ailment.

Mr. Sullivan, who as a boy studied bacteriology and law in his spare time, became associated with the food and drugs division in 1933, and was named director in 1947. He was past president of the Association of Food and Drug Officials of the United States.

Mr. Sullivan worked closely with and was highly regarded by Hoosier doctors who knew him to be instrumental in Indiana food and drug legislation, especially in formulating and securing passage of the Household Poisons Bill during the 1957 legislature.



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District, County News

First District

Newly installed officers of the First District Medical Society, elected at a May 18 meeting, are Drs. Gilbert Wilhelmus, president; Michael Monar, vice president; J. Guy Hoover, secretary-treasurer; Patrick J. V. Corcoran, alternate councilor; and George Willison, Blue Shield Board representative.

Third District

Dr. John M. Paris was re-elected councilor from the Third District at that society's annual meeting, May 11.

Fourth District

Dr. Lloyd Hisrich was elected president of the Fourth District Medical Society at Seymour on May 17. Other newly-elected officers include Drs. Charles Olcott, vice president; William Freeland, secretary; and Robert Reed, alternate councilor.

Fifth District

Members of the Fifth District Medical Society, at their May 17 meeting at Turkey Run State Park, elected Drs. Arnold Kunkler, president; Paul Siebenmorgen, vice president; A. W. Cavins, alternate councilor and Hubert Goodman, Blue Shield Board member.



"Your case is highly puzzling . . . we've never had sugar in the blood before in lumps!"

Sixth District

At a meeting May 11 in Rushville, members of the Sixth District Medical Society elected as officers for the coming year Drs. John A. Davis, president; Davis W. Ellis, vice president; Perry F. Seal, secretary-treasurer; William Tindall, councilor; and Frank Green, alternate councilor.

Ninth District

Officers of the Hamilton County Medical Society will also become Ninth District Medical Society officers upon their election in January, according to decisions made at the May 18 meeting of the district group. Dr. Kenneth O. Neumann, Lafayette, was re-elected councilor at the meeting, and Dr. Raymond R. Calvert, Lafayette, Blue Shield Board member. The 1962 meeting will be at Noblesville, May 17.

Allen

Dr. Henry W. Brosin, Professor of Psychiatry at the University of Pittsburgh, spoke on "Personality Patterns Seen in General Practice" at the May 2 meeting of the Allen County Medical Society in Fort Wayne. Eighty-five members were present.

Newly-elected officers of the society are Drs. Donald S. Painter, president; Chester H. Warfield, president-elect; Gerald R. Nolan, secretary; and George C. Manning, treasurer.

Delegates to ISMA include Drs. F. W. Brown, E. F. Senseny, F. A. Bryan, F. L. Schoen and E. D. Hamilton. Their alternates are Doctors J. F. Jackson, J. R. Ball, W. L. Bridges, A. J. Haley and V. C. Moeller.

Carroll

Dr. James Hull of Lafayette spoke to members of the Carroll County Medical Society on "Traumatic Pneumothorax" at their April 19 meeting.

In the interest of further reducing the danger of polio in the county, society members sponsored free injections of Salk vaccine at their offices on May 8, the cost being borne by the society.

Dearborn-Ohio

Dr. Joseph Black, Fourth District Councilor, spoke to members of the Dearborn-Ohio Medical Society at a May 11 meeting. There were 13 members present.

Continued

DISTRICT, COUNTY

Continued

Decatur

Ten members of the Decatur County Medical Society met April 18 at Greensburg to discuss expansion plans for the county hospital.

Elkhart

Dr. Forest M. Kendall is the new president of the Elkhart County Medical Society. Assisting him are Drs. William A. Paff, vice president; and Page E. Spray, secretary-treasurer.

Floyd

Twenty-three members of the Floyd County Medical Society met at New Albany May 12 for a general business meeting and legislative discussion.

Fountain-Warren

Members of the Fountain-Warren Medical Society saw a film on Cancer Detection at their May 4 meeting in Attica.

Hendricks

Dr. O. T. Scamahorn was elected delegate to ISMA convention at the May 23 meeting of the Hendricks County Medical Society. Dr. Malcolm Scamahorn will serve as his alternate.

Huntington

Dr. A. N. Ferguson of Fort Wayne spoke on "Differential Diagnosis of Abdominal Pain" at the May 9 meeting of the Huntington County Medical Society.

Jay

Dr. S. M. Hammond has been elected secretary of the Jay County Medical Society, to fill the unexpired term of Dr. Joseph Cronin.

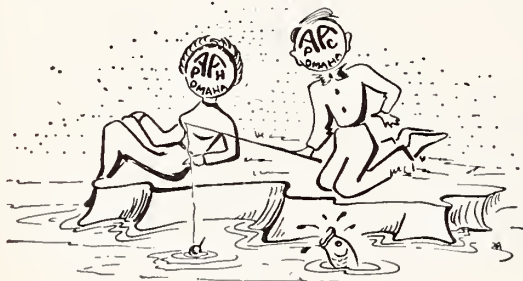
Vanderburgh

Dr. William C. Fisher is the newly-installed president of the Vanderburgh County Medical Society. Other new officers are Drs. Joseph McDonald, president-elect; Joseph E. Coleman, vice president; and A. W. Ratcliffe, treasurer.

St. Joseph

Newly-elected officers of the St. Joseph County Medical Society are Drs. J. M. Wilson, president; S. L. Egan, president-elect; Herbert Frank, secretary-treasurer; R. D. Dodd, assistant secretary-treasurer.

Delegates are Drs. W. D. Buchanan, M. E. Whitlock, R. A. Ganser and D. L. Dunlap. Their alternates are Drs. N. E. Sisson, S. R. Phelps, W. J. McCraley and C. F. Martin. Drs. R. L. Sanderson and J. O. Hildebrand, will serve on the Board of Trustees. Dr. C. O. Hamilton was named to the Board of Censors.



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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

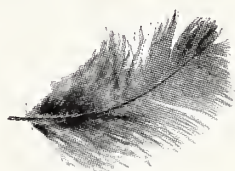
Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

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Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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it takes so little **MORE** to control it...
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References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy 18:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, in press. 3. Shaftel, H. E.: Clin. Med. 7:1841 (Sept.) 1960.



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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—The American Medical Association opposed three major provisions of a bill (S. 1552) that would greatly increase the powers of the federal government in regulation of the ethical drug industry.

These three provisions would turn over to the Department of Health, Education and Welfare and the Food and Drug Administration the responsibility for (1) relaying of drug information to physicians, (2) selecting the names of new drugs, and (3) deciding whether a drug is of value in treating human ills.

The AMA didn't take a position on the bill as a whole because certain of its provisions, "such as the Sherman Act and patent law amendments, are outside our area of competence."

Dr. Hugh H. Hussey, Jr., Chairman of the AMA's Board of Trustees and Dean of Georgetown University (Washington, D. C.) School of Medicine, was the chief AMA witness at the opening of hearings on the legislation before the Senate Antitrust and Monopoly Subcommittee headed by Sen. Estes Kefauver (D., Tenn.). Dr. Hussey was accompanied by Dr. Ernest B. Howard, Assistant Executive Vice President of AMA and C. Joseph Stetler, AMA's General Counsel.

LEGISLATION UNLIKELY NOW

With Congress trying for adjournment by about Sept. 1 and much "must" legislation still to be acted upon, it appeared highly unlikely that Congress would complete action on the drug legislation this year.

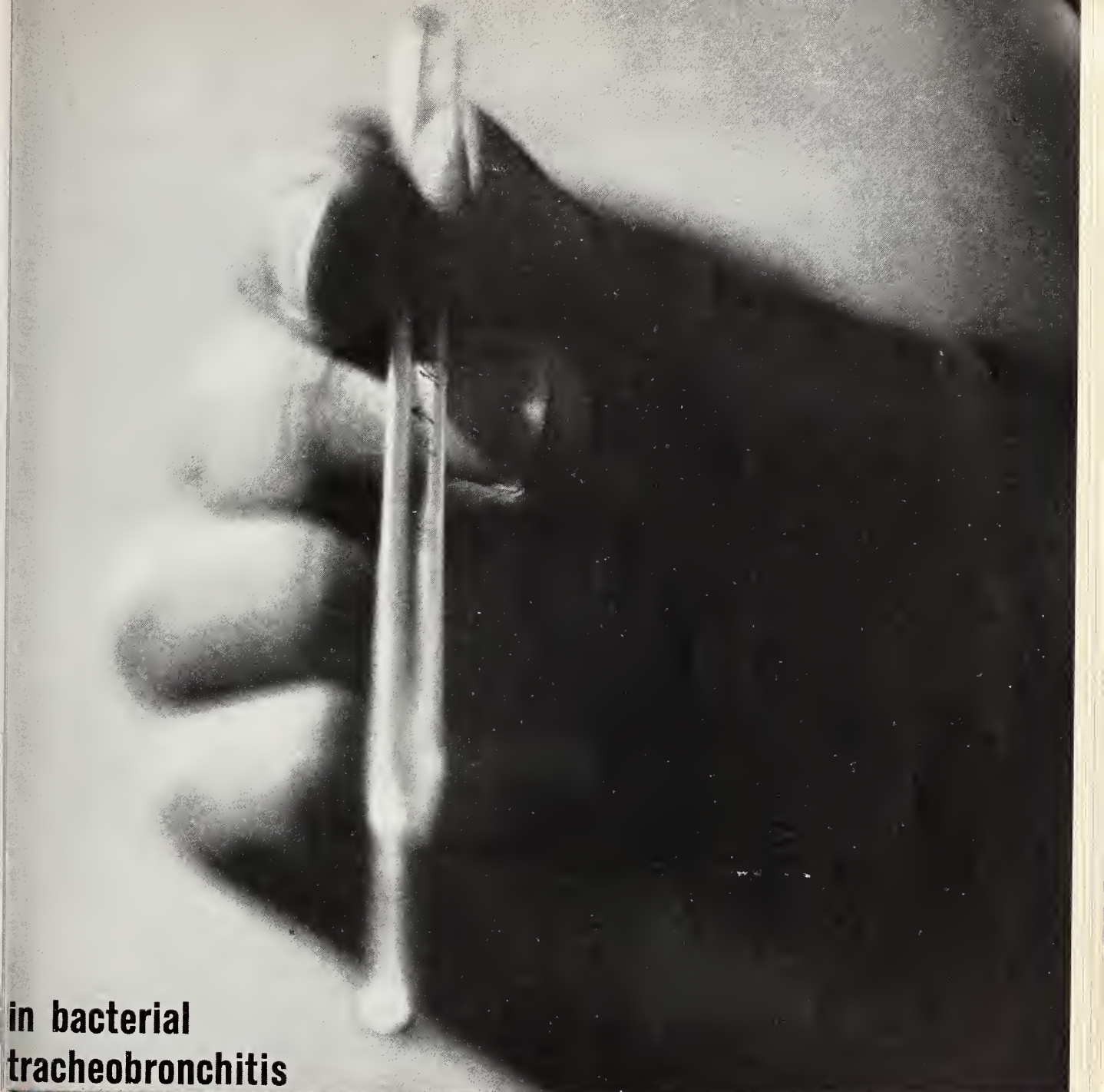
Dr. Hussey reviewed for the subcommittee AMA's 70-year-record of taking the lead in endorsing legislation designed to insure the purity of drugs and food. The AMA carried on intensive legislative efforts in the field and "is generally credited with being one of the major forces that brought the first Pure Food and Drug Act into being" in 1906, Dr. Hussey said.

Dr. Hussey cited these AMA aims that "we, as physicians, are desirous of achieving:

"- - - We want all physicians to be well-trained and fully informed on all aspects of the practice of medicine.

"- - - We want this body of knowledge and reservoir of skills to include a high degree of competence in the selection and proper use of drugs.

Continued



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Panalba*
promptly
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Panalba  your broad-spectrum
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Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.

Urticaria and maculopapular dermatitis, a few cases of leukopenia and agranulocytosis have been reported in patients treated with Albamycin. Most of these side effects usually disappear upon discontinuance of the drug.

Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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MONTH IN WASHINGTON

Continued

"- - - We want a continuing and expanding flow of useful drug products placed at the disposal of these physicians."

PRESENT AMA PROGRAM BEING IMPROVED

Dr. Hussey pointed out that the AMA already conducts an intensive program of informing physicians about new drugs and that this program is now in process of being greatly stepped up.

"The medical profession believes that the education of physicians is the responsibility and prerogative of the profession itself," he said.

Assigning responsibility for selecting names of new drugs to the federal government would merely be duplication of the program of drug nomenclature which has been operated for many years by the AMA and the pharmaceutical industry, Dr. Hussey declared. This program also has recently been refined and improved, and will continue to meet the need for an orderly system for selecting names for new drugs.

RESPONSIBILITY SHOULD NOT BE ASSIGNED TO GOVERNMENT

In the final analysis, it is the physician and the pharmacist who must know the non-proprietary names of drugs, he said. These two professions now direct this naming process, and "we do not believe the responsibility for designating and revising names should be assigned to a governmental agency", he said.

Regarding determination of the efficacy of a new drug, Dr. Hussey said:

"We believe that only the physician has the knowledge, ability and responsibility to make a decision as to what drug is best for a particular patient. He should not be deprived of the use of drugs that he believes are medically indicated for his patient by a governmental ruling or decision."

"Physicians seek to treat the medical problems of individual patients. A physician does not treat ten cases of hypertension, he treats ten individual patients, each of whom has a medical problem he has diagnosed as hypertension. He may find that the same dosage of the same form of the same drug will be efficacious in each and all of his ten patients.

"Or he may find that one or more of them need different dosages, or different forms of this same drug. He may, indeed, find that one, two or three of them are allergic to the non-active ingredients used in this brand of the drug, and that a different brand, with other non-active ingredients, is the proper answer.

"Thus, in one patient, a specific dosage of a specific drug might be said to be efficacious. While in another, it would be described as totally ineffective."

"A physician can be told many things about a drug, including its chemistry, its mode of action and, to some extent, its toxic properties. But he must judge its efficacy."

in rheumatoid arthritis

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OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

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for example:

SPECIAL PROBLEM: ANXIETY-TENSION

When triamcinolone was used, euphoria and psychic unrest rarely occurred. (McGavack, T. H.: *Clin. Med.* 6:997 [June] 1959.)

SPECIAL PROBLEM: OVERWEIGHT

No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

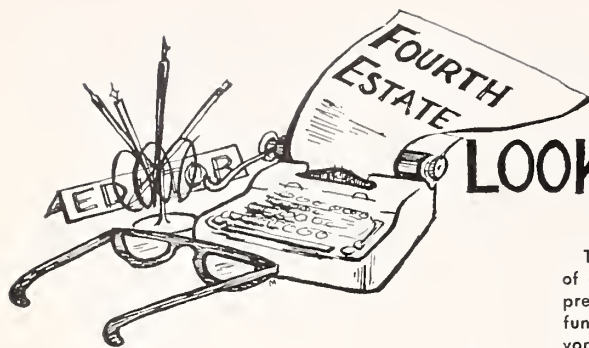
Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white). Also available—syrup, parenteral and various topical forms.



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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Sweat

By Inez Robb

NEW YORK—"Sweat," as Madison Ave. has convinced this nation, is a nasty word. Yet there must be millions of citizens still around premises who cut their teeth on the old biblical dictum that "in the sweat of thy face shalt thou eat bread."

A lot of us go away back to the days when there was no disgrace in doing any kind of labor, so long as it was honest, to keep the wolf from the door.

Now the small city of Newburgh, on the west bank of the Hudson River, 58 miles north of New York City, has created a national sensation by announcing it intends to resurrect the old biblical dictum in the distribution of public welfare.

In the future, Newburgh will require that all able-bodied men on relief be put in a 40-hour work week for the city on civic projects. Misplaced gallantry, apparently, prevented the city fathers from stretching the rule to apply to my sex.

Furthermore, there aren't going to be any more relief checks for able-bodied adult males or other physically able recipients (les girls) on relief who are capable of and available for private employment if they refuse to accept the honest jobs available to them.

These two simple rules, which seem basic and long overdue to me, are causing a donnybrook in some official circles. By insisting, wherever possible, that persons earn their relief checks Newburgh may lose its share of state and federal welfare funds.

Newburgh has laid down other rules, too, that go counter to state and Federal welfare practices.

But the heart of the matter, in one woman's opinion, is the re-establishment not of the right to work but the age-old principle of the duty to work.

If the good book tells us that we shall eat our bread in the sweat of our brow, it also admonishes us that we are our brother's keeper. Welfare legislation—local, state and Federal—in the past 30 years has paid increasing heed to the latter command while rejecting the former out of hand.

It is my belief, save in cases of exceptional hardship, that the two go together like Scot and Heather. For the life of me, I can see nothing cruel or degrading in asking the man or woman, whom the public treasury is supporting, to turn to and do such jobs as the city, county or state can make available.

Columbus (Ohio) Citizen-Journal
June 27, 1961

Reprinted with permission.

This Is A Bad Bargain

Fifteen of the 50 states carry the load for domestic programs of Federal aid. Indiana is one of the 15.

Every dollar received from the Federal government in grants to the Indiana state government and to local governments within the state costs the citizens of Indiana \$1.34 in Federal taxes. In some states the load ranges up to \$2.14 which is paid by the citizens of New Jersey for each dollar coming back into that state in Federal aid.

Thirty-five states are beneficiaries of the Federal aid programs. They get more in Federal aid money than their citizens pay in Federal taxes to support the programs. Some come close

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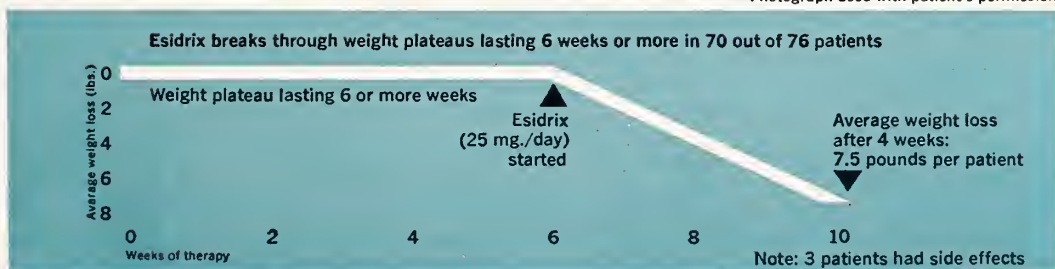
Weight problem? Start the reducing program right, keep it going right with **Esidrix®** **Esidrix-K®**

Recent studies show that the diuretic action of Esidrix improves results of weight-reducing programs 2 ways:

1. As an adjuvant in initiating treatment: Esidrix induces greater weight losses in the first few days than a conventional regimen.¹ This weight loss may be significant in itself (depending on the degree of fluid retention). But more than that, the quick loss of even a few pounds builds confidence in the weight-reducing program, inspires determination to follow it faithfully.
2. As an adjuvant in maintenance treatment: Esidrix eliminates retained water—with consequent weight losses—to break through the weight plateaus so often encountered in antiobesity programs. (See schematic graph below.) The new weight loss cheers the patient and helps overcome his tendency to eat too much.



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(Adapted from Einhorn and Kalb²)



For complete information about Esidrix and Esidrix-K (including dosage, side effects, and cautions), see Physicians' Desk Reference, or write CIBA, Summit, N. J.

References: 1. Ray, R. E.: To be published. 2. Einhorn, H. P., and Kalb, S. W.: Clin. Med. 7:1995 (Oct.) 1960.

Supplied: Esiorix Tablets, 25 mg. (pink, scored) and 50 mg. (yellow, scored). Esiorix-K Tablets 25/500 (white, coated), each containing 25 mg. Esidrix and 500 mg. potassium chloride. **NEW STRENGTH ESIORIX-K NOW AVAILABLE:** ESIDRIX-K Tablets 50/1000 (white, coated), each containing 50 mg. Esidrix and 1000 mg. potassium chloride.

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FOURTH ESTATE

Continued

to just breaking even. Rhode Island pays 99 cents for each dollar that comes back. Only half a dozen pay less than 50 cents on the dollar. Alaska pays only 16 cents for each dollar of aid received.

These domestic Federal aid programs now account for six to seven billions of the Federal budget. Last year Indiana's citizens paid \$175,700,000 of this total cost. Indiana got back \$130,900,000 in Federal aid.

If, on the average, each dollar of Federal aid was matched by one dollar of either state or local money, \$261,800,000 was spent in Indiana last year for the various activities which were carried out under Federal aid programs. But doing these things cost Indiana taxpayers \$306,600,000!

If there were no Federal aid, Indiana could be doing all these very same things and be saving the taxpayers \$44,800,000 a year! That's enough to build a fine new high school in every county of the state during the next 10 years.

Federal aid is misnamed. For Indiana and the other states which pay the bill it isn't aid at all. It's a handicap.

Indianapolis Star
May 16, 1961

Not Given a Fair Trial

The King bill (HR 4222) which would place hospitalization and nursing care under the social security system is about to have hearings before the House Ways and Means Committee in Washington.

Whatever the merits of this measure—and its chief fault is that it is a step toward socialized medicine—the surprising thing is that the Kennedy administration is pushing it when there already is on the books a law that hasn't even been given a fair trial.

This existing law is the Kerr-Mills Medical Aid for the Aged Act, which was passed by Congress last year. To date, 39 states have approved tying in legislation of their own to cooperate with the federal government in putting this law into effect. Why not give it a chance to see what it can do?

Moreover, private health insurance programs are expanding and since they are, there is less excuse for the government to get into the field and compete against private initiative. One rea-

son taxes are so high—and will go higher if the the government plan is adopted—is the government's insistence on competing against private enterprise in so many different fields.

If private enterprise will do the job itself, government intervention which brings heavy new costs for everyone paying taxes should be unnecessary.

Kokomo Tribune
June 1, 1961

Recognition of Quality

There is a new reason for pride in the general excellence of Indiana University's great medical school.

Its quality as a medical center has been recognized by a \$4,383,700 grant to be used for heart disease research, the largest single grant ever made to the medical school. Such huge sums as this are not handed out by the U. S. Public Health Service heart institute unless there is assurance that the recipient can use the grant most effectively.

The award is a distinct compliment to Dean John D. VanNuys, Dr. John B. Hickam, chairman of the department of medicine, and to members of the faculty.

Research is the basis for all advances of medical science against the killer diseases, of which heart disease is one of the most dangerous. The grant, spread over seven years, makes possible a huge expansion in the present heart research program at the school.

The public is justified in expecting that the long-range results of the program will be beneficial to heart disease patients. The high caliber of the medical school's staff is good reason for such faith.

Indianapolis News
June 22, 1961

The Parkinson Syndrome

Parkinson's disease, a not uncommon ailment among us senior citizens, is characterized by a stooped posture, a rather fixed gaze and a tremor in the hands.

Parkinson's law relates to an even more widespread ailment. It governs the phenomenon by which the need for spending money expands faster than the money available for spending. It explains why six months after a man has gotten a raise he's just as hard pressed for money as he was before.

Continued on page 1130



vertigo **is** reversible



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relief of symptoms
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Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959.

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five-factor geriatric supplement



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FOURTH ESTATE

Continued from page 1126

The Parkinson syndrome puts the two together, and is most prominently displayed in Congress when the lawmakers start appropriating money to build highways, meet the needs of education or to take care of us when we are old. The older we get the more the bills for these things seem to mount.

Just the other day, in a single session, Congress added a few more billions to the highway program, raised the Social Security payments to old folks while reducing the age at which we are legally considered old folks, and further extended the time we'll be allowed to pay off our mortgages. Naturally, at the same time Congress increased our taxes and decided to raise the \$293-billion government debt ceiling by another \$5 billion.

Now you mustn't suppose any of this was illogical. Before Congress acted, the minimum Social Security benefit was \$33 a month, which anybody must concede is pretty low. Congress raised it to \$40—and anybody would have to agree that is also pretty low. In fact, you can be sure that a few years from now everybody will be so agreeing, and Congress will raise it again, raising the taxes also to pay for it.

Formerly you had to be 65 to draw retirement benefits. The new law would lower the age to 62, and who's to say a man 62 isn't as entitled to aid as a man 65? Indeed, the way we feel right now we'd agree that age 60 is none too early to lay aside our labors.

The difficulty with all this began once the government accepted an "obligation" to see that everybody got a public pension when they passed a certain age, regardless of need or circumstance. Since even Congress has to use some arithmetic, this means that nobody gets very much, while the people's needs are always limitless.

Certainly there is no limit on the amount of money that can be spent on the elderly. As we collect our accumulation of ills with the passing years, who is to say we won't be better off hospitalized instead of sitting on the porch in a Kennedy-style rocking chair? And why should we sit around being a nuisance to ourselves and our kin if the Government will put us in a nice hospital?

This is Parkinson's law in its pristine form,

but it is nowise limited to medicare for the aged. No matter how many highways the Government builds there is always, somewhere, a "need" for another. The government is now arranging 40-year mortgages because it's the "government's obligation" to see to the people's shelter; but somewhere there is somebody in need of a nicer house for whom even a 40-year mortgage is too much.

Of course anybody who wonders about it all is an old fuddy-duddy who doesn't want the old folks to have nice hospitals in which to pass a carefree retirement, all at public expense.

And maybe all these things will be wonderful in our old age. What troubles us right now is that every year the cost of it all goes up and up, and the burden of paying for Parkinson's law is already giving us a stooped posture, a rather fixed gaze and a tremor in the hands.

Wall Street Journal
June 29, 1961

From Other Editors:

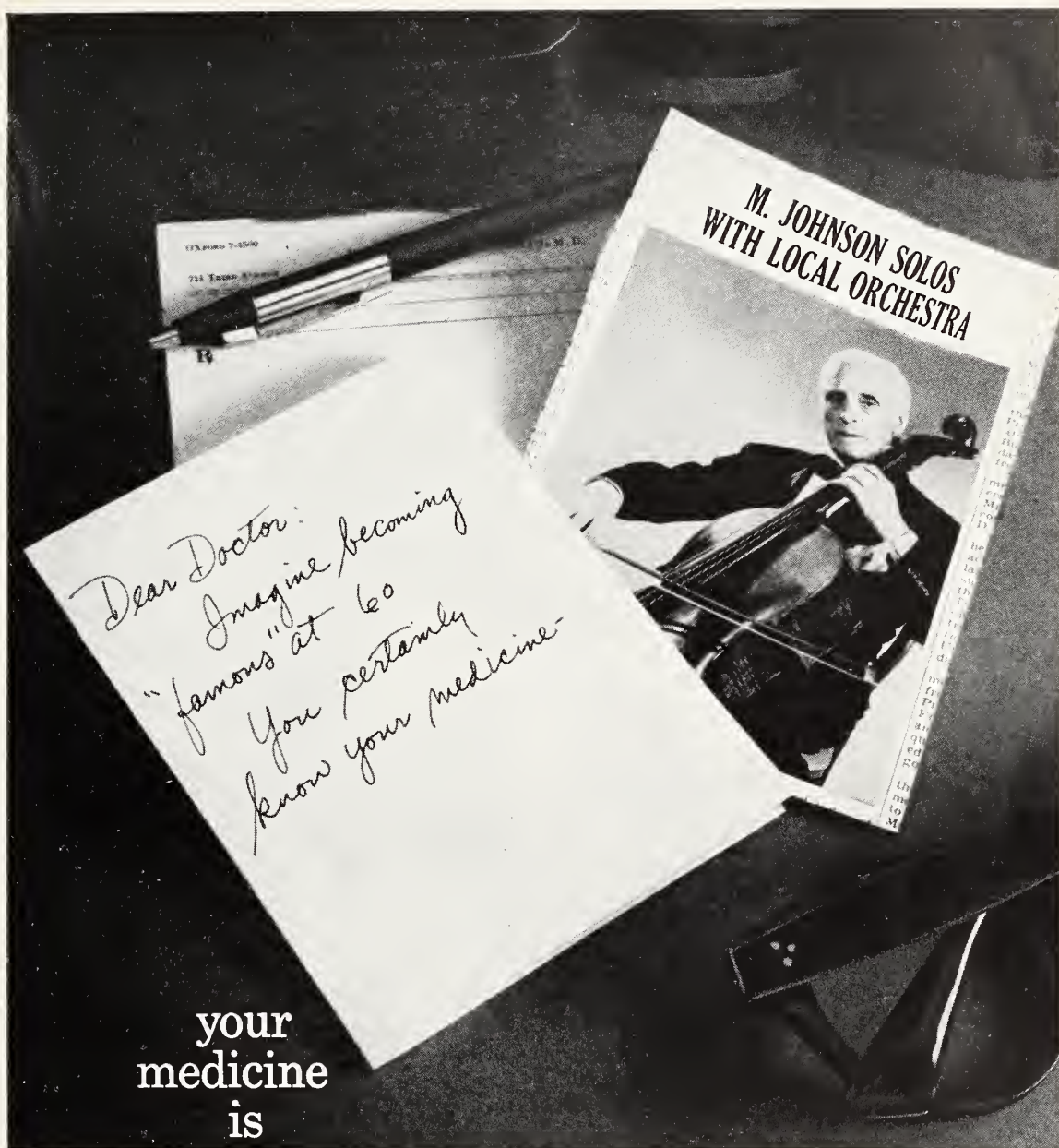
Free Medicine: How 'Free'?

A letter from a reader challenges a recent *Enquirer* editorial concerning President Kennedy's program for broadening social security to include medical care for the nation's aged. The letter specifically takes us to task for contending that the program as recommended by President Kennedy will be financed by the federal government. Instead, he writes, it will be financed through social security, which, in turn, means equal contributions from employer and employee.

It seems to us that denying that the federal government would pay for medical care—even under social security—is like denying that the federal government pays for national defense.

The federal government, in reality, is wholly without resources. Whatever it has, whatever it "gives" to the states, to local communities, to individuals, it first—or later—takes from them in the form of taxes. The same is true of social security; for the social security tax is a tax just as surely as the income tax or excises.

This letter, however, results in large measure from a massive public relations campaign undertaken by the social security system and the Department of Health, Education and Welfare of which it is a part. The campaign is aimed at convincing the American people that social se-



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one capsule every morning supplements the diet to help achieve proper balance: ❖ nutritionally ❖ metabolically ❖ mentally

Each dry-filled capsule contains: Ethinyl Estradiol, 0.01 mg. • Methyl Testosterone, 2.5 mg. • d-Amphetamine Sulfate, 2.5 mg. • Vitamin A (Acetate), 5,000 U.S.P. Units • Vitamin D, 500 U.S.P. Units • Vitamin B₁₂ with AUTRINIC® Intrinsic Factor Concentrate, 1/15 N.F. Oral Unit • Thiamine Mononitrate (B₁), 5 mg. • Riboflavin

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mental iron, 10 mg.), 30.4 mg. • Iodine (as KI), 0.1 mg. • Calcium (as CaHPO₄), 35 mg. • Phosphorus (as CaHPO₄), 27 mg. • Fluorine (as CaF₂), 0.1 mg. • Copper (as CuO), 1 mg. • Potassium (as K₂SO₄), 5 mg. • Manganese (as MnO₂), 1 mg. • Zinc (as ZnO), 0.5 mg. • Magnesium (MgO), 1 mg. Supply: Bottles of 100 and 1,000.

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FOURTH ESTATE

Continued

curity is simply a form of insurance with the federal government as the insurance company.

The campaign suggests that medical care would be substantially the same. Contributing to a medical care fund under social security, in other words, would be no different from contributing to some privately financed health insurance program. Once you have contributed, the government is in your debt; it owes you certain benefits and dividends when you retire or otherwise establish your eligibility.

But this story is far different from the one the social security system tells.

Here, for instance, are excerpts from a brief filed before the United States Supreme Court by the Secretary of Health, Education and Welfare in October, 1959:

"The OASI program is in no sense a federally administered insurance program under which each worker pays premiums over the years and acquires at retirement an indefeasible right to receive . . . a fixed monthly benefit. . . . The contributions exacted under the . . . program are a tax. Unlike private insurance . . . the social security program needs no such reserves, since it is assured of continuing participation by the exaction of taxes.

"The social security concept is of a program under which those with jobs in their productive years, their employers and persons engaged in self-employment are taxed chiefly to provide the funds for current benefits to beneficiaries.

"Consistent with the noncontractual nature of OASI benefits is the ruling of the Internal Revenue Service that monthly benefit payments are voluntary payments to the recipient by the government. . . . and hence within the scope of . . . (a section) . . . exempting from taxation the value of property acquired by gift."

There is, we believe, a substantial distinction between a "right" and a "gift." And that distinction is one Americans should understand.

Reprinted from the *Cincinnati Enquirer* in *Kokomo Tribune*, June 30, 1961.

Compulsory Polio Shots?

Debate about polio vaccines will do a disservice if it dissuades parents from having their children, and themselves, inoculated with Salk vaccine this year. Purportedly superior oral vaccines won't be available in quantity until 1962,

and—as U. S. Surgeon General Luther L. Terry said April 6—"our job is to use what we have." That means every American should complete a series of four Salk shots.

Dr. Jonas E. Salk, developer of the first anti-polio vaccine, has warned that paralytic polio could strike 1,000 persons in the United States this year who lack vaccine protection. Statistical evidence showing efficacy of the Salk vaccine is compelling. For example, 2,218 cases of paralytic poliomyelitis were reported in the United States in 1960. Of the persons affected, 1,252—or over half—had had no vaccine and only 160 had received the recommended four doses. Fortunately, 1960 was a record low year for polio, but Providence, R. I., and Baltimore, Md., suffered epidemics of almost 100 paralytic cases in each city.

As of April, 1961, about 62% of Americans of the age of four or under had received three or more doses of polio vaccine. In the 5-9 age group, the figure was 84%; in the 10-19 category, 80%; but in the 20-39 age group only 45%. Again this year the Public Health Service is imploring local authorities to push vaccination campaigns.

Some communities have increased their inoculation percentages by sponsoring clinics where the polio shots are available at cost. Civic associations, church groups, volunteer fire departments and other organizations frequently take the lead in setting up these mass inoculation programs. For those who will not protect their children voluntarily, compulsory immunization may provide an effective, if unpopular, means of immunizing the population. North Carolina and Ohio and many communities now require polio vaccinations as a condition of entry into the public school system. Smallpox has been virtually wiped out in this country by such strict provisions.

Kokomo Tribune
June 8, 1961

Rub of the Green

It was Saturday morning and while they were having breakfast, Mr. Smith suddenly announced that he didn't have to go to the office that morning.

"Well, don't think," said his wife, "that you're going to run off and play golf today and leave me alone with all this work to do."

"Why, golf is the furthest thing from my mind," replied the husband, yawning at his breakfast, "and please pass me the putter."—*Wall Street Journal*, reprinted in *Copsuled Comments*, July, 1960.

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General Practitioners' Issue

Problems of Common Household Poisonings

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Indianapolis

MUCH HAS BEEN SAID and written about accidental poisoning. It is not my object in this short time to review all the poisonous agents, discuss their mode of injury and prescribe the proper antidote or treatment. We all have manuals or books which devote chapters to single agents. It is my desire to stimulate your interest in some small manner in order that you may be more aware of this problem of accidental poisoning, the frequency with which it strikes, and its prevention and treatment.

Most Common Pediatric Emergency

Accidental poisoning is the most common medical emergency encountered in pediatric practice. Each year, more than 1500 normal, healthy children lose their lives because of parents' carelessness or as a result of the child's own curiosity. Ingestion of drugs left within

reach of the small child contributes to this danger. A word of caution will frequently alert the parent or other adults about the danger of common medications when they are ingested in excessive amounts.

Toddlers and younger children are the chief victims. Nearly half of the poisonings occur in children under five years of age. The two, three and four-year-olds are the most frequent victims of internal medications. Children under one year of age are less likely to poison themselves because they are less mobile, but when they are old enough to toddle around and investigate available articles left in their reach the incidence of accidental poisonings skyrockets.

Homes with inadequate storage space, small homes which are over-crowded, constitute the greatest risk. Therefore, the lower socio-economic level has the highest incidence. One of the notable exceptions is the practicing physician and dentist who carries his samples home like a pack rat, and carelessly leaves them scattered around his home. Most of us have a miniature

* Presented before the annual meeting of the Indiana Academy of General Practice, March 16, 1961, Indianapolis.

apothecary shop at home, filled with fatal poisons. Perhaps new federal regulations to control sampling by detail men may lower the incidence in our profession.

A mother's slightest distraction, such as the ring of the telephone, a knock on the door or a call from another child upstairs is enough to drop her guard, and with this lapse of vigilance, the other child is once again filling his mouth with articles that may result in death.

The multiplicity of drugs, both common and prescription items, increases the risk of accidental poisoning in children; aspirin, barbiturates, tranquilizers, weight pills and iron preparations are only a few of these readily available potential killers. We must find a way to impress parents of this great danger.

The first place to start is with our own profession; initiating a campaign that must extend down to the guardians of our younger generation. Publicity in newspapers, and on radio and television make a good start. Articles in periodicals, such as mothers' magazines are also excellent means of attracting attention. Proper labeling by the manufacturers and verbal caution by the druggists are a "must." Committees on accidental poisoning in state and local medical societies create an interest in this problem. Lay organizations are always anxious to cooperate and frequently will accept this as a project for their members. Our own academies of general practice and pediatrics should have active committees. We have a state committee in American Academy of Pediatrics and I'm sure you also have a similar one.

Great Strides in Prevention

Prevention is the key. Our local, state and federal health organizations have made great strides in this direction. We have in Indianapolis, as in many other cities, a poison control center at General Hospital. All other hospitals also have card files and handbooks on poisoning. These are as close as our telephone when we seek information. The State Board of Health also maintains a poison control center where they provide information on poison content and the drugs used to combat the condition. They are not authorized to prescribe or treat, but make the information available, so you will be well enough informed to treat the condition correctly.² Interested physicians may obtain a di-

rectory of poison control centers by writing to the:

U. S. Dept. of Health, Education, and Welfare

Accident Prevention Program

National Clearing House of Poison Control Centers

Washington, 25, D.C.

The American Medical Association provides a card index for doctors who wish to establish poison control centers. Setting up and maintaining a local poison control center in every county hospital admitting room should be a must for the county medical society. Larger cities are able to provide more elaborate facilities, but the function remains the same. The reporting of all poison cases brought to our local hospitals is prompt. Reports are checked and followed through by our county board of health. Forms, available at the local hospital, are completed and forwarded to the county health officer. In New York City, before a poison control center was established, less than 100 cases of poisoning were reported a year.³ In 1959, it rose to 10,000 since it is now mandatory to report all poison cases.

Drug manufacturers are now more careful to stress contraindications and dangers of overdosage. New federal legislation following the Kefauver investigation of pharmaceutical houses now makes it mandatory to spell out the danger of certain toxic drugs and enclose a warning. Manufacturers of household products have been persuaded to employ safer chemicals in their products. Deletion of lead in common household "do it yourself" paints is a result of this effort. Our own legislature a few years ago passed a law requiring registration of any article sold to the public which contains a poison. The fee from this registration helps maintain the Department of Poison Control, Indiana State Board of Health.

The American Association of Chemical Manufacturers attempted to define what constitutes a poison. Their definition stated that it is the amount that would kill 10 mice (minimum lethal dose). This definition is not adequate since this would make carbon tetrachloride non-poisonous to humans. The State Board of Health was able to insert into our law, "What experience has found to be poisonous." Here the

profession has an opportunity to monitor the products that are found to be poisonous.

General Principles of Treatment

Ingested Poisons: Overtreatment of a poisonous agent with large doses of antidote, sedatives or stimulants often does more damage than the poison.¹ The following principles should be remembered:

1. If a poison is taken by mouth, remove the unabsorbed poison. This may be done by emetic, lavage or removal of source.
2. Identify the poison. If labeled, call the poison control center to identify the ingredients.
3. Administer an antidote.
4. Give antagonist when available.
5. Give symptomatic treatment as indicated.

The universal antidote is neither universal nor antidote, but is excellent when no specific antidote is available.

Universal Antidote

Pulverized Charcoal—Burned Toast—2 parts
Magnesium Oxide—Milk of Magnesia—1 part
Tannic Acid—Strong Tea 1 part

Inhaled Poison: Remove patient from source of gas and apply artificial respiration.

Injected Poison: Application of a tourniquet, central to the point of injection may slow absorption. Specific antisera, when available, are imperative.

Most Common Accidental Poisonings in Childhood⁴

1. Salicylates
2. Sedatives
3. Bleach and Lye
4. Petroleum Derivatives and Turpentine
5. Pesticides.

1. *Salicylate (Aspirin):* Mild toxic reactions are frequent, but serious poisoning is also common.

Two situations where salicylate intoxication may occur:

1. Accidental ingestion of aspirin or oil of wintergreen.
2. Mistaken dosage on part of parent or physician in treatment of febrile diseases. A recommended dosage of aspirin is one grain/1 year of age/q.4h. Methyl salicylate *very dangerous*. The odor is appetizing, and one teaspoonful is equal to sixty grains of aspirin.

Abnormalities in Metabolism Produced:

1. Acid-Base Balance—
Respiration Alkalosis
Metabolic Acidoses
2. Disturbance in blood coagulation

First toxic effect:

Hypernea → CO₂ blown off in excess →
CO₂ combining power falls → pH rises →
produces Respiration Alkalosis

Compensatory Mechanism of the kidney, liver and respiratory system responds resulting in Metabolic Acidosis.

A bleeding tendency also constitutes a problem. Salicylates exert an anti-Vitamin K or Dicumarol-like effect. Prothrombin production is impaired.

Treatment

1. If seen within a few hours, stomach lavage with hypotonic saline solution.
2. When large amounts are ingested, intravenous infusion of five percent glucose and isotonic saline up to six to eight hours. Six to eight hours after ingestion we should use one part 1/6 molar sodium lactate, two parts isotonic saline, and three parts five percent dextrose in water.
3. Vitamin K to prevent hemorrhage.
4. Blood transfusions and barbiturates may be needed in all serious cases.

2. *Sedative Intoxication:* The second most common drug killer. Doses five to six times hypnotic dose are usually toxic.

Treatment consists of lavage, analeptics and oxygen. It is not good practice to lavage comatose patients. Use of 500-1000 c.c. of a hypotonic saline and potassium permanganate 1:5,000 is recommended. Stimulants of caffeine, ephedrine and Coramine may be beneficial. Picrotoxin is thought to be the analeptic of choice. A new drug known as N. P. 13, or megemide, is useful.

3. *Bleach and Lye Ingestion:* Most of household bleaches are composed of hypochlorite solution or oxalic acid. Where hypochlorite is at fault, one should lavage immediately and give olive oil or a thin flour paste. If oxalic acid is at fault, the poison can be treated with a 1:5,000 potassium permanganate lavage followed by calcium chloride, chalk or lime water solution with large quantities of water.

Lye is the most common cause of residual esophagel strictures. Use mild acids such as dilute vinegar or lemon or orange juice. A Levine

COMPOUND	SYMPTOMS	PATHOLOGY	TREATMENT
Ammonia	Burning eyes	G.I. (Gastro-Enteritis)	Weak Acids
Carbon Tetrachloride	Headaches, Hiccough	Kidney Damage	Symptomatic
Carbon Monoxide	Headache & Vertigo	C.N.S. (Central Nervous System)	5% CO ₂ with 95% O ₂
Methyl Alcohol	Delirium & Inebriation	Respiratory & C.N.S.	Gastric Lavage
Toadstools	Abdominal cramp, nausea, vomiting & diarrhea	Kidney, Liver & C.N.S.	Lavage, tonic acid & Atropine sulfate
Iodine	Brownish discoloration of lips, thirst & vomiting	G. I. & C.N.S.	Emetic, egg white, 1-5% Sod. thiosulfate
Digitalis	G. I. followed by mental confusion—arrhythmia (cardiac)	Heart	Lavage & symptomatic
Iron Compounds	Vomiting, G. I.—Circulatory collapse	Liver	Calcium Demulcent & protective agents, Edathamil (EDTA) calcium disodium
Boric Acid	Erythema & Exfoliation—skin	C.N.S.	Symptomatic
Aniline Dye	Cyanosis	C.N.S. & Circulatory failure	1% Methylene blue, I.V.
Lead	G.I.—Mental Disturbance	C.N.S.	De-lead, EDTA
Jimson Weed (Stramonium)	Thirst—Dilated pupils	C.N.S.	Lavage—4% tannic acid
Moth Balls (Naphthalene)	G. I.—Black urine	Liver, Kidney	Lavage
Camphor & Camphorated Oil	Headache—G. I.—Tachycardia	C.N.S.	Symptomatic
Deodorants (Thallium)	G.I.—Cerebral	C.N.S.—Liver—Kidney	Lavage with Sodium Thiosulfate
Acetone (fingernail polish remover)	Bronchial—Fruity odor breath	Death from Ketosis	Symptomatic—Respiratory stimulant
Cyanide (Silver Polish)	G. I.—Cerebral	C.N.S.	0.5 Sodium Nitrate—I.V.

TABLE I

tube is best left in place to lessen the stricture formation. The exact time of bougie dilatation is debatable, but early introduction is favorable.

4. *Petroleum Derivatives and Turpentine:* This group includes kerosene, benzene, fuel oil, furniture and floor polish, along with turpentine. The problem of a secondary lipoid pneumonia is paramount.

Here, the use of lavage is controversial. I, personally, feel that removal of the poisonous agent is important, but one must use care to avoid aspiration, and prevent additional pneumonia.

5. *Pesticides:* This group includes a large number of insecticides and rodenticides. Rodenticides include several toxic agents such as arsenic, thallium, phosphorus and strychnine. Lavage and

use of B A L is effective in arsenic. Thallium poisoning requires one percent sodium or potassium iodide or sodium thiosulfate. Strychnine is best treated with intravenous barbiturates even before lavage. Acute phosphorus poisoning should be treated with lavage and 0.2 percent copper sulfate.

Table I reviews some of the very common, readily accessible household poisonings, and some of their pathology as well as a brief word on treatment.

Summary

1. Poisoning is the most common and most serious pediatric medical emergency.
2. It is necessary to be familiar with agents causing poisoning in children.

3. Prevention: Instruct parents in the risk of poisoning and point out safeguards they should adopt.
4. Alert parents on safe handling and storage of medications and poisonous household products.
5. Familiarize self with the functioning of nearest Poison Control Center
6. Educational program through academy and local medical societies; publicity through press, radio and television.
7. Removal of samples from office and home.
8. Keep ready reference of American Medical Association cards. P. D. R. (Poison section), Poison Handbook or other readily available reference.
9. Continue current familiarization of new findings in toxicology.
10. Be not afraid to admit your unfamiliarity with a specific toxic agent. Consult readily available sources of information and then contact the patient immediately. *Delay can mean Death.*

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"We are convinced that he (the individual citizen) can spend his own life and spend his own money better than some possibly benevolent bureaucrat. All agree it is criminal for one man to steal from another. But over-powerful government can rob the individual just as surely—only the scale is grander, the stakes are greater, and the loss far more tragic. For what is stolen by paternalistic government is that precious compound of initiative, independence, and self-respect that distinguishes a man from a mob, a person from a number, a free man from a slave."—Dwight D. Eisenhower.

Alcoholism

An epidemiologic study
of a common disease.

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LET US APPROACH the problem of alcoholism without fixed mental prejudices which we have been subjected to in our past experiences. This is rather difficult for most of our society. We subconsciously have had our opinions biased by confused pictures presented to us through varying attitudes of a multiplicity of approaches to the problem. One needs only to mention the fact that this disease has, for years, been approached as a sin by our clergy, as a crime by our purveyors of justice and as a madness by the scientific members of our profession.

Extent of the Problem

It has been estimated that there are 65,000,000 persons in this country who drink alcoholic beverages; and of this number there are 5,000,000 alcoholics. The number includes only graduate alcoholics—not the undergraduates. Assuming that each of these alcoholics affects the lives of 25 other people in the course of his alcoholism, it is easy to understand that few people go through life lacking some close association with this problem. The association may be a relative,

friend, employee, employer, client, parishioner, clergyman, patient or a personal physician.

To assume that *this* body of readers is a non-alcoholic group would be the greatest alcoholic assumption that was ever made.

Alcoholism is not a respecter of person or kind. It is found in all segments of our society. So let us rid ourselves of the idea that an alcoholic is a man lying in the alley behind a warehouse, on skid row, covered with newspaper, with four days' growth of beard on his face and with a bottle of wine in his hand. This particular group constitutes only about six percent of the alcoholic population. The other 94% are seemingly normal people in our communities, with whom we associate knowingly or unknowingly. When you read that there are 6½ male alcoholics for every female alcoholic, remember that these statistics are derived from those who come to public attention, and remember that the greater number of women alcoholics are sheltered in homes by their families; hence they do not come to the public's attention. Recently it was stated that there is an increase in alcoholism among women. Is this true? Or is it due to the fact that community attitudes are changing—allowing these female alcoholics to seek help without the shame and stigma of our past generations?

* Presented at the annual meeting of the Indiana Academy of General Practice, March 16, 1961, Indianapolis. The second part of this paper will appear in the September *Journal*.

True facts taught in our schools—without prejudice:—if you drink you have one chance in 13 of becoming an alcoholic. If you and your husband or wife drink, you have one chance in 6½ of having an alcoholic in your home. These odds are not very good, and there is no way, yet, of predicting who will become an alcoholic.

In industry we find six per 100 employees are alcoholics, and perhaps six others who are married to alcoholics and whose efficiency is reduced. Yet printed material has been distributed to industry stating that the problem there is not important. Problems of alcoholism rarely are allowed to reach top management due to protective natures of foremen, supervisors or personnel men. Do they feel that disclosure might signify to their superiors personal failure to handle these problems?

In communities where death certificates have been followed up, to rule in or out the presence of alcoholism as the basic cause of death, it is found that alcoholism is the third to fourth leading cause of death. It is needless to tell you that alcoholism is not found on many death certificates. It is hidden under the guise of pneumonia, tuberculosis, liver disease, gastric or pulmonary hemorrhages, ruptured peptic ulcers, accidental, suicidal and homicidal deaths.

Attitudes Concerning Alcoholism

It is essential, if we are going to be able to do anything about this general public health problem and assist the alcoholic in the solution of his problem, that we adopt neither a wet nor a dry attitude but rather a middle of the road concern for those afflicted with this disease without moralistic or criminal attitudes.

General community attitudes may be a beneficial motivating force in the salvage of the alcoholic, or the condemning force which drives him to utter destruction.

Definition

Let us now take a look at the disease (dis-ease) of alcoholism without the prejudices of our past.

Perhaps your education, medically, was like mine. My medical education on alcoholism can be included entirely in one sentence. One day our medicine quizmaster said, "The next chapter is on alcoholism, sometime in the next two years you might read it. Next week we'll take up typhoid fever."

In June of this year I will have been gradu-

ated from medical school 27 years. I have in this period of time seen two cases of typhoid, one while in school in the University Hospitals and the other at Fort Knox during World War II. In the past 11 years I have seen, individually, or in groups, 50,000 alcoholics.

In a Canadian research publication I found a definition which I feel is complete and basic enough, in which we have a working definition:

"Alcoholism is a disease characterized by an individual's uncontrolled use of alcohol which leads to the basic cause of a growing and continuing problem in any or all departments of his life."

The word, "uncontrolled" signified addiction. If we accept the opinion of the Committee of Experts on Drugs Liable to Produce Addiction, World Health Organizations, it is as follows:

"A state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug. Its characteristics include:

- (1) An overwhelming desire or need (compulsion) to continue taking the drug and to obtain it by any means;
- (2) A tendency to increase the dose;
- (3) A psychic (psychological) and sometimes a physical dependence on the drug."

Most of us who have become well acquainted with an alcoholic would feel that the definition of an addict fits our friend very well.

There is one exception of the alcoholic pattern to this definition. Addiction to all other drugs usually causes increased dosage, due to tolerance, (except plateau addicts who level their dosage for economic reasons). In alcoholic addiction tolerance to the drug is built up for varying periods of time, with increasing intake, then the tolerance pattern reverses itself and it takes less and less of the drug to produce like effects. Once this tolerance is lost it can never be regained regardless of intervening periods of sobriety. This explains the fact that the alcoholic is never able to return to being a "social drinker" regardless of how hard he tries. "Once an alcoholic, always an alcoholic"—practicing or non-practicing.

Addiction proceeds through three phases (1) habituation; (2) emotional dependence . . . rhyme and reason; (3) physical dependence . . . at which stage there is a physical compulsion to

use the drug to treat the symptoms of his addiction.

I have one diagnostic question to ask the sober alcoholic: "Is drinking giving you trouble?" When physical, mental, domestic, financial, occupational, social, and legal troubles are particular segments discussed in the presence of wife, husband, or parents, then truer answers may be obtained.

During this interview with husband and wife it is many times harder to tell which is the alcoholic, and one comes to the conclusion that they are both crazy. The disease of alcoholism is a family disease, and its effects are broken down to these percentages: 40% of the disease process is found in the alcoholic; 50% in the mate, and 10% in the rest of the family.

Diagnosis

Diagnosis of alcoholism needs to be made by those who meet the individual when he is in trouble. This procedure, called pin-pointing the problem, may be carried out by our medical directors and personnel men in industry; our clergymen in their family counseling; our peace officers, attorneys, and judges in the courts; our physicians in the course of treating patients for their withdrawal symptoms, and their fami-

lies—for nervousness, sleeplessness, and anxieties. Many children's physical and mental maladjustments are due to a catastrophic drinker within the home.

The pamphlet, "Who Me?" prepared by AA as a diagnostic aid contains the diagnostic questions prepared at Johns Hopkins as a guide, and has added five of its own which—if honestly answered by the individual—will assist the individual in gaining insight as to the basic nature of his problem.

Basically the alcoholic is a combination of the addict-prone personality and alcoholic addiction: the emotional immaturity of omnipotence, doing and accomplishing in a hurry, wanting what he wants when he wants it, the way he wants it; never grateful for what he has or gets, which leads to frustrations (which are the temper tantrums of the immature adult). In seeking escape, solace, refuge, freedom from his frustrations, and an escape from reality by the use of alcohol (man's first tranquilizer) he finds himself an addict with impaired judgment . . . imprisoned within the small confines of a bottle, losing what he sought—and remorseful!! ◀

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Dr. Harvey Kravitz of the Department of Pediatrics, University of Illinois, appeared before the Indiana Academy of General Practice at its Annual Meeting on March 16, 1961, and described a new technic for smallpox vaccination. The method is described and illustrated in an article by Dr. Kravitz published in *Pediatrics*, February, 1961, Vol. 27, No. 2, page 219.

A multiple tipped scarifier, made of either metal or plastic, is used to press once through a drop of vaccine placed on a prepared area of skin. The scarifier may also be used by placing a drop of vaccine upon its points and pressing the points into the prepared skin. The method produces as high or higher percentage of "takes" as the standard multiple-pressure method. It produces smaller and cosmetically superior scars. It is less painful and does not produce a fear reaction as readily as the long steel needle of the conventional method.

Orthopedic Examination of the Newborn

Early recognition. Early treatment. Best result.

GEORGE J. GARCEAU, M.D.*

Indianapolis

CONGENITAL DEFORMITIES of various degrees of severity are extremely common, but fortunately, deformities of a severe nature are relatively rare. However, every practicing physician encounters these deformities and therefore a little review is always in order. We concern ourselves now with orthopedic deformities.

The diagnosis of congenital deformities of interest to the orthopedic surgeon may be classified in two main groups, those so obvious that they are detected at time of delivery, and a group which is not so easily detected.

We will only list those deformities apparent at birth:

1. Clubfeet.
2. Clubhands.
3. Congenital absence of limbs in part or whole.
4. Congenital contractions.
5. Supernumerary toes.
6. Syndactylism of fingers and toes.
7. Macrodactylism.
8. Microdactylism.
9. Cleidocranio dysostosis.
10. Congenital Synostosis of Cervical Spine (Klippel-Feil Syndrome).

11. Harelip and cleft palate.
12. Meningomyelocele.

The second group are less evident at birth, and a searching examination may be necessary to make an early diagnosis:

1. Congenital dysplasia and dislocation of the hip.
2. Congenital dislocation of the knee, rare.
3. Calcaneovalgus.
4. Vertical talus.
5. Metatarsus adductus.
6. Mild degrees of clubfeet.
7. Congenital elevation of scapula.
8. Congenital muscular torticollis.

Peculiarly enough, congenital deformities of severe degree which are readily detected at birth are frequently very difficult to correct or may even be uncorrectible, such as congenital absence of limbs, macrodactyly, microdactyly, cleidocranial dysostosis, Klippel-Feil Syndrome, and meningomyelocele. Contrariwise, the deformities which may be hidden at birth are usually correctible and excellent results may be obtained when treatment is started soon after birth. We will consider only the more common deformities.

Congenital Dislocation of the Hip

Congenital dysplasia and dislocation of the hip are fairly common. Until recent years the diagnosis was seldom made before the child began to walk — all too frequently too late to

* Presented at the Annual Meeting of the Indiana Academy of General Practice, March 16, 1961, Indianapolis.

achieve a good result. Although the anatomy involved was accurately described in 1826 by Guillaume Dupuytren, over 100 years passed before the signs of dysplasia and dislocation of the hip in the infant were generally recognized. Many pioneer orthopedic surgeons added piece by piece certain features which contributed to the early diagnosis. Lorenz popularized the so-called bloodless method of reduction. Unfortunately, the end results were poor in at least 75% of cases because the reduction was attempted too late.

Only by diagnosis in the first year of life and prompt treatment has the incidence of excellent result been increased. Consider that an infant triples its weight in the first year of life and it then becomes apparent that remodeling of the reduced dysplastic or dislocated hip has the best opportunity to develop into a normal hip. Experience with many patients proves this to be true. Putti of Italy taught this, but his teaching was disseminated slowly.

Congenital dysplasia and dislocation of the hip is found about eight times more frequently in girls than boys. It is more often unilateral than bilateral. It is rarely found in the Negro and occurs most frequently in the Latin people.

It is more easily recognized in unilateral cases. The mother may notice that when the hips and knees are flexed one knee is lower than the other, the so-called Allis sign. The posterior aspect of the thigh may have an extra crease. The greater trochanter is more prominent. Abduction of the hip is limited on the affected side. Pushing upwards on the extended thigh will reveal telescoping, sometimes called piston-like motion. In many cases a click of entry or exit can be felt on manipulation of the hip. Following the click of entry of Ortolani it may be possible to further abduct the hip. In the rare frank dislocation the head of the femur can be felt. This is not possible in the dysplastic hip, which becomes actually dislocated after the infant begins to crawl and walk. Finally, x-ray examination is always indicated when the deformity is suspected. If these simple signs are sought in the routine examination of an infant the incidence of early diagnosis will greatly increase and normal hips will be obtained in ever increasing numbers. Since this presentation is concerned with diagnosis, I shall not discuss the treatment.

Congenital Calcaneovalgus

It is generally believed that talipes calcaneovalgus is more rarely encountered than talipes equinovarus. Some observers believe this deformity to be increasing while that of talipes equinovarus is decreasing. It appears to be increasing because physicians are more aware of the deformity and therefore the mild type is now detected. The moderate and severe types have always been recognized.

This deformity is characterized by abnormal dorsiflexion of the foot at the ankle, apparent lengthening of the Achilles tendon and eversion of the foot. In the mild cases the foot is easily corrected by manipulation. The severe type cannot be so easily corrected due to contracture of the anterior group of muscles, especially the anterior tibial muscle. The tendon of this muscle may become prominent when the foot is brought into equinus. In the more severe deformity the top or dorsum of the foot may approximate the front of the lower leg. Many children born with mild degrees of talipes calcaneovalgus later show signs of pronated flat feet. Those with severe deformity practically always have flat feet unless treated vigorously for several months.

Congenital Metatarsus Adductus (Varus)

This deformity consists of a turning inwards of the forefoot at the tarsometatarsal joints, so-called adductus or varus. Rarely is the forefoot inverted. It has been called "skewfoot." The incidence is said to be increasing; frequently the deformity is not noted until the infant is two or three months old. Infants spend much time in the prone position with the hips and knees flexed and with the feet turned inwards. This position probably aggravates the adductus and accounts for the discovery of the deformity sometime after birth rather than soon after birth. Untreated feet usually result in persistent deformity and in some cases may eventually be the precursor of hallux valgus and flat feet. Early diagnosis and treatment always achieves complete correction. Correction may also be rapidly obtained in older children, but the period of treatment is prolonged.

Vertical Talus

Vertical talus is actually a congenital dislocation of the talonavicular joint and the subluxation of the calcaneus under the talus. This deformity is frequently mistaken for calcaneoval-



FIGURE 1
(Top left)

DYSPLASIA OF LEFT HIP with subluxation. Note apparent shortening of left femur when knees are equally flexed and held together. Known as Allis sign.



FIGURE 2
(Top right)

DYSPLASIA OF LEFT HIP with subluxation. Note extra crease in left thigh and prominence of left trochanteric area.



FIGURE 3
(Lower left)

DYSPLASIA OF LEFT HIP with subluxation. Note extra crease in left thigh.

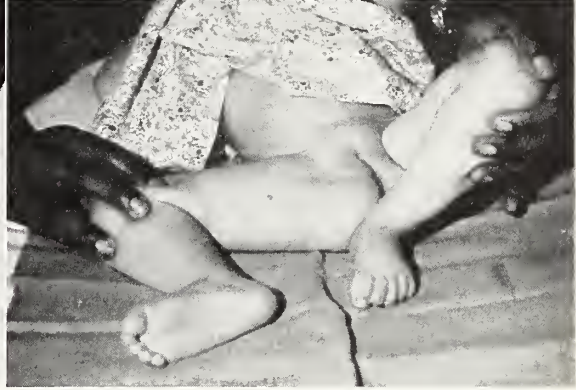


FIGURE 4
(Lower right)

CONGENITAL DYSPLASIA of left hip. Note limited abduction. The "click" is usually felt when manipulation is performed.

gus. In calcaneovalgus the heel points downwards and the Achilles tendon is long. In vertical talus the heel points upwards (in equinus) and the Achilles tendon is short. It is very important to differentiate these two deformities. Calcaneovalgus is easily corrected. Vertical talus is one of the most difficult deformities of the foot to correct. X-ray films always reveal the calcaneus to be in equinus. In older children the talonavicular dislocation is well demonstrated by x-ray examination. In our experience open surgery has always been required and even then the results are rarely satisfactory, although improvement is obtained.

Talipes Equinovarus

Talipes equinovarus, commonly known as clubfoot, remains one of the most frequently encountered of all congenital foot deformities. Our studies indicate an hereditary factor in over 25% of our cases. A more accurate study now

being conducted appears to reveal a much higher incidence of hereditary tendency.

Cause of the deformity remains unknown. However, gross abnormalities in muscle tendon insertions in the foot, abnormal development of some or all of the muscles below the knee, and absence of one or more muscles below the knee all suggest arrested development during intra-uterine life.

The diagnosis is usually easily made at time of birth because the deformity is so apparent. There are three main components to the deformity. The foot points downward and the Achilles tendon is short. This is known as equinus. The whole foot is turned inwards, varus, so that the sole of the foot faces medially. The forefoot is in adductus position, curving inwards.

This deformity is usually difficult to correct but persistence by the physician and the parents usually results in satisfactory correction although an absolutely normal foot is seldom

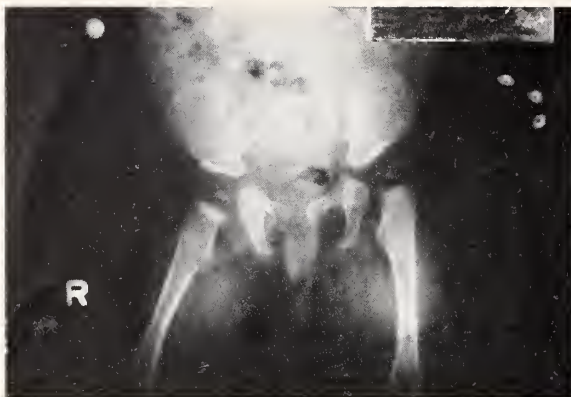


FIGURE 5
July 26, 1958. **DYSPLASIA OF LEFT HIP** with subluxation. Note roof of left acetabulum, small bone centrum of epiphysis which is separated from acetabular floor.

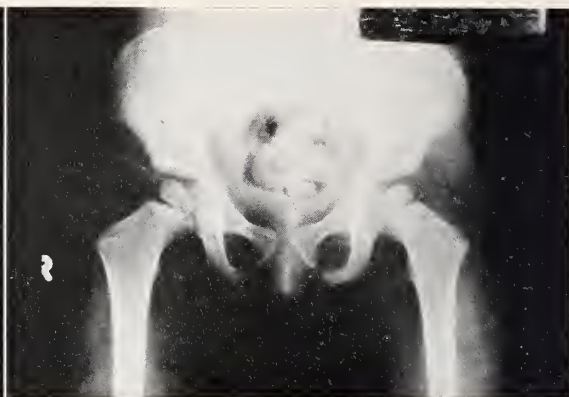


FIGURE 6
SAME PATIENT, Feb. 8, 1960—18 months later, at the age of 2 years. Normal hip.



FIGURE 7
(Left)
TALIPES VARUS, a partial clubfoot, similar to metatarsus adductus.

FIGURE 8
(Lower left)
METATARSUS ADDUCTUS, uncorrected, in a seven-year-old boy.

FIGURE 9
(Lower right)
BILATERAL HALLUX VARUS, a type of metatarsus adductus.



achieved. Recurrence of the deformity is difficult to prevent and therefore the follow-up care must be unrelenting.

Congenital Muscular Torticollis

For generations the cause of muscular torticollis was believed to be an injury to the sternomastoid muscle. Many infants who developed torticollis were born by breech delivery and in such instances it was believed an injury to the muscle had occurred. In 1875 Frederick Taylor studied the sternomastoid muscle of a six-week old infant who had died. He stated that the muscle fibers had been displaced and destroyed by the growth of fibrous tissue between the bundles of muscle fibers. He used the term "sternomastoid tumor."

In 1944 Chandler and Altenberg demonstrated that there was extensive degeneration of muscle tissue, fibrous tissue replacing muscle fibers.

During the past 15 years we have studied over 50 infants who developed a tumor in the neck. The tumor or mass is usually noted in the third or fourth week of life although in some cases it was noted soon after birth. We have removed the mass in about 25 cases. The youngest infant

was operated at the age of 18 days, the oldest at 11 months. No sign of injury to the muscle has ever been found. The mass reveals no signs of injury such as discoloration, hematoma, granulation tissue or inflammation. Hemosiderin has not been found on microscopic examination. We therefore concur that congenital muscular torticollis is not traumatic in origin. We believe it is a congenital defect. This entity should be taken out of the category of birth injuries.

The treatment is usually delayed until contracture of the muscle occurs. In some cases the mass disappears and leaves no deformity.

Congenital Elevation of the Scapula

Congenital elevation of the scapula (Sprengel's Deformity) is due to failure in the migration of the scapula from the embryonic occipital position. It may be unilateral or bilateral. The degree of deformity may be mild or very severe. The diagnosis is not difficult. Examination readily reveals the cephalad position of the scapula. Abduction of the arm at the shoulder is usually limited.

Treatment of the deformity requires surgery. The scapula is dissected free of muscular at-

FIGURE 10
(Right)
CONGENITAL VERTICAL TALUS in boy of seven years. Sometimes called congenital convex foot.

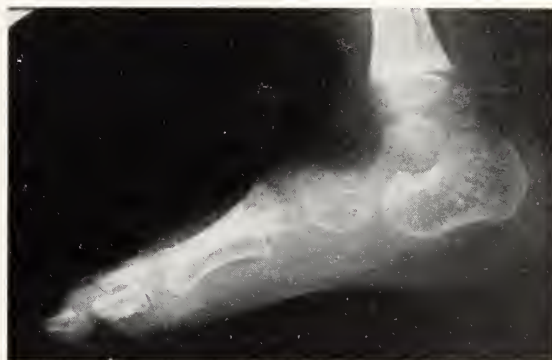


FIGURE 11
(Lower left)
TYPICAL EXAMPLE of clubfeet in a newborn infant.

FIGURE 12
(Lower right)
SAME INFANT as Figure 11, well corrected at two months of age. Correction must now be maintained.





FIGURE 13
THREE-MONTH-OLD female. Note skin excoriation under
the "tumor" caused by contracture of sternomastoid muscle.

tachments and pulled downwards where it is attached to the bits and spinous processes of the vertebrae.

Congenital Dislocation of the Knee

Congenital dislocation of the knee is a very rare deformity. There are two types. Congenital hyperextension of the knee is easily detected because of the unusual motion in the knee. True dislocation, an exceptionally rare deformity, is characterized by inability to flex the knee because the tibia is displaced anteriorly on the condyles of the femur and the patellar ligament is very short. Early treatment in the first type achieves a normal knee joint. The treatment in the second type is difficult but satisfactory knees are achieved when reduction is obtained early. When dislocation of the knee is associated with arthrogryposis the prognosis is poor.

Conclusions

We have discussed only the more common deformities which when treated early and efficiently result in practically normal individuals. We have emphasized early diagnosis because only then will early treatment be initiated. The total number of types of congenital deformities is so great that consideration is prohibitive in a discussion of this type. Only the really practical aspect has been considered.

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Modern Hospitals

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BEFORE ONE discusses present day hospitals it is necessary to gain an understanding of their history and development to some extent, showing the evolution of our present-day emporiums of health.

Hospitals are as old as civilization itself. It appears that civilized man has always been interested in better health not only for himself but also for his fellow man. This interest in his less-fortunate brethren seems to have motivated the starting of hospitals in ancient times as well as today.

Our earliest knowledge of hospitals dates back to the sixth century B.C., although there is reason to believe that such institutions existed among the Sumerians in 4000 B. C. *M.D.* magazine, which for the past two years has been giving a history of medicine by eras or times, stated that ancient Babylonia had buildings set aside for the care of the infirm, aged etc. as well as temples of healing which could be construed as hospitals in the modern sense.

Hindu literature records that six centuries B. C. Buddha built hospitals for the care of the crippled and poor. As early as 226 B. C. hospitals in India practiced many of our present day routines, namely, the attendants gave gentle care to the patients, prepared and gave medicines, massaged the patients, and wore white clothing while caring for the sick. They were required to keep themselves and the patients clean at all times.

The Indians of America set aside buildings for residences of the sick while they were being administered to by the medicine men. Concern for one's fellow man prompted many of these institutions then as well as today. Religious feel-

ings also prompted the start of many hospitals, especially in the dark ages of Europe.

The first hospital in the new world was started in Santa Domingo by Commander Ovando in 1503. It was adjacent to a church, the Chapel of St. Nicolas de Bary.

The oldest existing hospital in the new continent was founded in Mexico City in 1524 by Cortez and was called the Hospital of the Immaculate Conception. In 1663 the name was changed to the Hospital of Jesus of Nazareth and it functions today under the same name in Mexico City.

The first record of a hospital built in what today is the United States of America was in 1663. It was built by the Dutch on Manhattan Island to care for sick soldiers.

The first hospital in what we think of as present day United States was Old Blockley in Philadelphia, started in 1732. It originally was one room set aside for the care of the sick in one of the many alms houses in Philadelphia, which were started by William Penn. It, because of the need for more space, was moved to Blockley Township a few years later, hence the name Old Blockley; and in 1742 it became the Philadelphia General Hospital.

'Modern' Thinking in 1755

Philadelphia also had the first private non-profit hospital in the United States. The hospital, quite modern in design by today's standards, consisting of a central administration unit with two adjacent wings, was opened in 1755. Three doctors, Thomas Bond, Phineas Bond and Lloyd Zachry made up the staff. This is today's Pennsylvania Hospital in Philadelphia.

One could spend hours going into the history of hospitals from the time of Aesculapius. The Greeks and Romans had well organized hospitals albeit they ministered more to the soul

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than the body until the time of Hippocrates, who was born in 460 B. C., and who placed more emphasis on facts than faith.

Ancient hospitals had personnel and labor problems much as we do today. One celebrated reformer, John Howard, wrote of the hospital of St. John of Jerusalem in Malta in 1786 that the patients were served by "the most dirty, ragged, unfeeling and inhuman persons I ever saw. I found eight or nine of them highly entertained with a delirious dying patient." This hospital was started in 550 A. D. by the emperor Justinian.

As late as 1769 New York City, with a population of 300,000, had no hospitals. New York's first hospital was built in 1771, as a result of a fund drive. The building had a maximum of eight beds to the ward, with good light and ventilation. The interior, burned when nearly completed, was rebuilt and opened in 1776. It fell into the hands of the British and was used by them during the Revolutionary War.

Other early American hospitals were Bellevue in New York in 1816 which actually started in 1736 as one room set aside in a workhouse for the care of the sick. It was moved to its present location in 1796. Massachusetts General was opened in Boston in 1811 and Boston Lying In in 1832. The first record of an insane hospital as such in the United States was at Williamsburg in 1773. A hospital for mental disease was started in 1798 in Baltimore at the present site of Johns Hopkins. New York Dispensary was started in 1791.

The first Federal hospital dates from the passage of the United States Marine Hospital Act in 1798. Two such hospitals were opened in 1802, one at Boston, the other in Norfolk, Va.

Nothing has been said about early European hospitals such as Hotel Dieu at Lyons, France 542 A.D., Hotel Dieu at Paris 600 A.D., St. Bartholomew's in London 1123, which was built with publicly donated funds. They will be merely mentioned in passing as will the one Cappadocia, mentioned in Caesar's orations, St. Basil in Constantinople 335 A.D. and the numerous hospitals built by the Mohammedans, the greatest of which was probably Al-Mansur in Cairo, built in 1276.

The major portion of the above information

was taken from the book *Hospital Organization and Management* by Malcolm T. MacEachern, M.D., C.M., F.A.C.P., F.A.C.H.A. and the book *Hospital Trusteeship* by Charles U. LeTourneau, M.D.

Nursing Is Key Foundation

Proper tribute is due nursing, and especially Florence Nightingale, who, during the Crimean War in 1854, was commissioned by the English Government to correct hospital procedures in the army hospitals. Miss Nightingale had been trained at Kaiserswerth on the Rhine, one of the first nursing schools ever established as such. She was dismayed by the care of the sick, and on return to England, put her own ideas to work with such remarkable success that her army commission followed. She brought orderliness and cleanliness out of the chaos by organizing food, diet, medicine, laundry and nursing services, etc. by which the mortality rate was reduced from 40% to less than 5%. I think it can be truly said that modern hospitals and hospital administration started with Florence Nightingale.

The history of hospitals is indeed interesting, but my purpose now is to talk about today's hospitals primarily from the standpoint of management and utilization by patients and doctors. I will try to project into the future, as indicated by present trends, what hospitals will tend to become and do.

The art and science of operating or managing a modern hospital is growing more complex due to the rapidly expanding field of hospital services and the more rapid advances of scientific medicine. I am thinking in particular of general hospitals but the same principles apply to highly specialized hospitals as well.

Within the lifetime of our youngest doctor medicine has made its greatest strides in history but in doing so has added tremendous burdens to hospitals.

What is a hospital? What is its place in the national economy? What is the future of hospitals? These are questions we will attempt to answer.

In the overall picture of national economy, from the standpoint of money collected and spent, hospitals rank fifth in the nation. They are really big business and show every evidence of becoming even bigger.

What Is a Hospital?

What is a hospital? It consists of a building first. Doctor John Jones, who designed New York City's first hospital in 1771, showed remarkable foresight and wisdom in that his design called for a central administration unit and attached wings of wards.

Secondly comes engineering of all sorts, i.e., mechanical, electrical, structural, sanitary, chemical, etc., to make the plant operate efficiently and economically.

Housekeeping is probably third in importance. The job of keeping a hospital clean, including floors, walls, laundry, etc., is of tremendous importance in hospital management. Reducing spread of infection is always a major concern and without good housekeeping, would be virtually impossible.

Food service naturally is important—especially dietary service—both must be operated efficiently and economically. Food service is quite a problem to maintain and operate. The fact that many large institutions have changed from individual kitchens on the floor to food carts from a central kitchen, and then to individual trays made up in a central kitchen and transported to the floors in special carts, indicates that the problem is not easily solved. The use of individual trays at present seems to be a good method in that the dietitian can supervise the making up of the trays very easily and be sure that patients get the proper diet.

Nursing care, of course, makes up a major portion of hospital business. You are so familiar with this aspect that nothing more will be said, but this does not depreciate the importance of nursing care in the hospital's overall function.

Administration and board of trustees are not easily separated in the management of a hospital. Today's hospital administrator is a highly-trained individual who needs to know quite a bit about the practice of medicine in general, and to have a knowledge of accounting, personnel management, purchasing, cost analysis and cost accounting as well as insight, tact and good judgement. In most hospitals he is the main liaison between the board of trustees and the medical staff. Most hospitals today have liaison committees, but the administrator serves an important function in conveying to the elected staff officers the thinking of the board. Without good

administration today's hospitals would be in chaos.

Board is Overall Management

Modern hospitals are so large and complex and the ramifications of managing one so varied that some group who can see the woods instead of the trees is necessary. Such a group is the board of trustees. Their election varies with different hospitals but in general the overall makeup follows a pattern.

Qualifications for a trustee, as listed by Dr. LeTourneau in his book *Hospital Trusteeship* published in 1959, are honesty, personal disinterest, substance, leadership, integrity, dedication to public service, good education, willingness to learn, an inquiring mind, progressiveness, cooperativeness, objectivity, common sense and time to serve properly.

Those suggested are financiers, lawyers, engineers, educators, business executives, safety engineers, clergymen, newspaper editors, career civil servants, and possibly doctors. More will be said about doctors on the board later.

The board is the overall management of the hospital both financially and medically; to see that it is efficiently and economically operated, that proper standards of care are maintained, that discrimination against either patients or doctors is not practiced and to set rates for rooms and other services with the advice of the administrator and staff officers. The board is the final authority in operating the hospital.

Board members function without pay. Aside from attending regular meetings, they work on various committees such as financial, contractual, grounds and buildings, legal, insurance, public relations, liaison and others.

Physicians as Board Members

A major function of physician board members is to interpret medical matters to the other members. A very vital and sensitive facet of the hospital operation is the relationship, both professional and economic, with radiologists and pathologists. It is quite important that the physician board member not limit his interest and activities to medical matters. Physician board members become quite informed on such subjects as budgets, cost accounting, investments and bricks and mortar. Good hospital management encompasses many different types of skills and talents; while the attorney, banker and

engineer are laymen regarding medicine, they are professionals in their respective areas. We need only to read medical economics to realize the importance of the attorney to hospital operation and for that matter, the practice of medicine.

Since doctors on the board have functioned so well, I have sought to determine the philosophy of the American Medical and American Hospital Associations on this subject. As far as I can determine neither association has any definite policy concerning such service, but the American Hospital Association apparently feels that a doctor cannot serve on the board, have patients in the same hospital, and still have personal disinterest. Dr. LeTourneau states definitely in his book that a physician should not try to fulfill both functions.

I personally disagree with him: Doctors have a definite place on the boards of general hospitals of moderate size or larger. They should be in the minority, however, comprising not more than one third and probably not more than one fourth of the board as a whole. I think the doctors should be older men who can and will meet the qualifications. I have served on such a board for four years, have gained invaluable information and knowledge of hospital management, have gained a greater respect for hospital administrators and especially have admired and respected the lay members of the board, dedicated individuals giving greatly and unstintingly of their time and talents to the institution with which they are associated.

The medical staff is the most important part of a hospital. You have heard many times, and seen in the public press, and you probably will see and hear it more often in the future, that hospitals exist for doctors, that they are workshops for doctors; but this is a mis-statement. Hospitals exist because of doctors. Hospitals, as such, cannot and should not try to practice medicine. Only licensed doctors can practice medicine, and they should not let hospitals take this prerogative away from them. This does not mean that the staff and/or individual doctors should not cooperate. They should cooperate fully and work together for better understanding and mutual welfare and for the very existence of each, individually.

In the complex institutions of modern times communications is probably the one most important function. The two best means of good

communications are, doctors on the board, and an active staff with alert functioning officers and department heads properly elected, yearly, in democratic fashion, to co-ordinate the overall functions of the board, administration and staff.

Hospitals, Doctors Inseparable

In the past the public image has been that of the hospital as separate and independent from doctors. As stated above hospitals exist because of doctors and the two are inseparable. The staff must assume its responsibilities, work in close cooperation with administration and the board, be willing to work individually and collectively for the general good, serve freely on committees and keep proper records. Administration must be ever alert to seek ways in which the staff can help in general management.

The running of a well-departmentalized hospital, (all hospitals of fifty or more beds should be departmentalized), is an enormous task calling for much special information and is too great a task for one administrator to shoulder. Department heads should be elected by the staff, with proper attention given to ability as well as willingness to serve. The administrator should consult frequently with department heads as well as other officers to see that the various departments are functioning properly. Department heads should not hesitate to discuss problems of their departments with the administrator and if necessary these discussions should be confidential until proper committee action has been taken.

Numerous committees are necessary for the proper functioning of the hospital. Among these are executive, administrative, records, tissue, credentials, nursing, utilization, professional standards, infection control and others as well as special committees to be appointed as occasions arise. Common sense dictates that these committees will be better informed as well as much more efficient if the chairman is a voting member of the executive committee.

Someone once said, "An individual does his best work in pleasant surroundings, preferably of his own choosing, and while working with others who are equally happy in their work." In plain terms doctors and hospital personnel will do better in democratic surroundings such as should exist in a hospital where there is harmony. With each individual shouldering his share of the responsibility, properly respecting and showing deference for others, regardless of

status, and willing to cooperate for the common good, any hospital organization can have harmony, and as a result, the patients will get better care.

Present Trends Evidence Future

What is the future of hospitals as evidenced by present trends? Present thinking in hospital planning tends toward the round type of construction for more efficient and economical operation. Increasing costs of operation makes it imperative to include as many labor saving devices as technology can produce. Labor is the largest item in cost of operation, running over 65% of the total budget; every labor saving device will more than justify its original cost.

Change of attitude as to the future basic organization of patient care will differ remarkably from the present. Future hospitals will be organized into probably four basic types of care, intensive, average nursing (probably better called convalescent), self help and some form of nursing home care. Patients who are ambulatory and hospitalized for special studies will eat in a common dining room, go to x-ray and laboratory on their own.

Directional arrows, color coding and proper scheduling could easily eliminate the unnecessary labor of having orderlies or maids take basically well patients to these facilities.

Quick-frozen food trays could be made up at regular hours, heated in the new ovens available which will heat a frozen tray in a very short time, and served by a much smaller staff than is now necessary. At present much kitchen and

serving help is needed three times a day; yet in between meals they are largely unnecessary.

New electronic devices monitor a patient constantly for pulse, respiration, temperature, etc. thus freeing nurses for other work.

Much of the present detail of keeping nurses' notes will be done by electronic machines as will much of the routine blood analyses that are done in the laboratory. However, no electronic machine nor technological device can replace the perfect formula for a good hospital, namely, teamwork, tact and tender loving care.

Proper credit is due the American Hospital Association, founded in 1898, and the work of the American College of Surgeons in setting standards for hospitals as well as for their original inspection and approval program. The Joint Commission on Accreditation, which was born in 1952, possibly prematurely, has grown out of the incubator stage and now seems settled on a basic course which will see hospitals become even greater than ever.

In conclusion—What is a hospital? The best organized welfare service on the continent today. Possibly churches and schools are larger and as well organized but they do not directly care for the sick. Business management, professional care, mechanical operations, public relations and the sincere personal interest of everyone in the picture must be coordinated and well-directed to make an efficient democratic hospital. In other words teamwork, tact and tender loving care. ◀

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Griseofulvin: Practical Usefulness and Limitations in Fungus Infections

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Gary

THIS IS A CLINICAL REPORT of results obtained in the treatment of 101 cases of ringworm with griseofulvin—54 involving the scalp, 23 involving the skin, and 24 involving the skin and nails. All were private patients. The basic facts about this drug (chemical, pharmacological, biological, and experimental, etc.) have been amply covered elsewhere and are not repeated.

Only cases proven by culture are reported; any diagnostically doubtful ones having been removed from the list. The dosage used was the average: 1 gm per day in adults, and approximately 10 mgm per pound body weight per day in children, given in three or four doses per day. Larger dosage schedules and single mass dosage (3 or 4 gms) was not tried in this group of cases.

In the scalp cases the hair was clipped close or shaved after about three weeks of treatment, and in the nail and cutaneous cases an undecylinic acid ointment was used locally along with the griseofulvin tablets. All nail patients were asked to clip and file away diseased nail as the treatment continued.

As this drug has been rather generally accepted as relatively non-toxic, only spot check complete blood counts were done (about 10%). No unusual blood pictures were seen.

One of the cutaneous cases could take no more than 250 mgm daily without gastrointestinal upset. This was the only reaction to the drug noted.

Ringworm of the scalp: 54 patients were started on griseofulvin treatment, and 41 were cured, the cure being well-established by Wood's

light examinations and cultures at least two months following cessation of active treatment. Treatment days necessary for cure varied from 20 to 100.

Ringworm of nails, skin of the trunk and extremities, and of the groin: 47 patients in these categories were treated. Of seven groin cases, five were probably cured in two months of treatment. All other cutaneous and nail cases improved, but not one is certainly cured, even though the treatment has been continuous for from six to 10 months.

CONCLUSIONS AND COMMENTS

On the basis of the early reports, the writer could hardly wait to start using griseofulvin. Based on his impressions after having used the drug for about six weeks on 10 or 12 patients, his enthusiasm was running very high. After nearly a year's experience with over 100 patients treated, his enthusiasm has waned considerably, and older methods of treatment are being used again, even though reluctantly.

Ringworm of the Scalp

In ringworm of the scalp this drug will cure nearly all cases—perhaps all cases. It is believed that the prolonged periods of treatment required for about half of the scalp cases in this series would have been unnecessary had one continuous seven or eight-week course been used for all patients at the start. In the scalp cases presently selected for treatment with griseofulvin this is the method used by the writer, and it seems to be working out very well.

Valuable as this drug certainly is in scalp ringworm, this writer hardly believes it should

SCALP CASES—54
Cured 41; Result Unknown 13

RESPONSIBLE ORGANISMS	TOTAL DAYS OF TREATMENT						FAILED TO RETURN FOR FOLLOW-UP
	Less than 30	30-40	40-50	50-70	70-100		
M. Audouini	48	7	11	1	6	12	11
M. Canis	2					2	
Tr. Mentagrophytes	1				1		
Tr. Tonsurans	3		1				2
Total	54	7	12	1	7	14	13

TABLE I

replace all other methods of therapy. With small, few, localized patches, local medication, such as the undecylates, will still cure many in a reasonable time—quite often two or three months. Some of the animal types are still often self involuting, and many of these require only palliative treatment. X-ray epilation for scalp ringworm is still valuable, especially when used on children from homes where there is not too much co-operation or understanding, and likely to be little chance for follow-up. Treatment essentially completed in one call has its advantages. The drug is valuable in scalp cases where the child is not sufficiently co-operative to epilate, on account of his age or for other reasons. The writer is presently using local treatment, griseofulvin, and x-ray—sometimes all three at the same time, in different children in the same family. Individualization has its place here, as it does in the use of many other methods of treatment in many other conditions.

Ringworm of Nails and Skin

In ringworm of the groin some patients were apparently cured, but it is not too difficult to cure most of this type with local medication. It is speculated whether patients in this classification, resistant to local therapy, might not also be just as resistant to griseofulvin. The number of these cases in this series is too small to merit definitive conclusions, however.

When it comes to ringworm involving the nails, feet, palms and soles, and other glabrous skin areas the results in this series of cases are not very encouraging. Well over 1/3 of all these patients have dropped from observation, most of them discouraged after several months of treat-

ment with little progress. There is not one patient in the remaining number in whom a cure seems remotely likely before a year or more of treatment. It is doubted whether any of this group of patients will continue treatment for a longer period than one year, and the writer doubts whether any should and whether he would himself under similar circumstances. No new nail cases are being started on griseofulvin, and only selected cutaneous ones. Perhaps griseofulvin combined with removal of the nails is worth investigating.

A word in regard to the economics of this drug is pertinent. The drug alone, if purchased via prescription, would cost, to cure a scalp case from \$20.00 to \$40.00, depending upon the child's weight. A year of treatment for an adult, for the drug alone would be something like \$250.00 or \$300.00. This estimate allows nothing for the physician's fee. The griseofulvin used in these cases was supplied partly by one of the drug houses, partly by the V.A., and partly at wholesale cost by this writer. For the sake of this investigation, professional fees charged were next to nothing. Had this group of cases been treated on a full-scale fee for service basis and the drug at prescription rate, it is very doubtful if there would have been enough cases to be worthy of a report.

It goes without saying that diagnostic procedures such as K O H smears, the Wood's light and cultures are a must if using this drug. Many non-fungus conditions have been seen after having received a course of griseofulvin for a supposed fungus infection, no sure diagnosis having been established.

CUTANEOUS and NAIL CASES—47

Possibly Cured 5; Under Treatment (6-10 Mos.) 23;
Dropped from Observation 19; Cured Certainly 0.

NAIL CASES		DURATION OF TREATMENT			FAILED TO RETURN DROPPED FROM OBSERVATION
		2 Mo.	6 Mo.	9 Mo.	Over 9 Mo.
Tr. Mentagrophytes	8		3	3	2
Tr. Rubrum	16		4	7	4
Total	24		7	10	1
<hr/>					
CUTANEOUS CASES					
Tr. Mentagrophytes	3			2	1
Tr. Rubrum	13		1	1	10
Total	16		1	3	1
<hr/>					
GROIN CASES					
Tr. Mentagrophytes	2	1	These 5 patients were observed 2 months after completion of treatment and seemed to be definitely cured.		1
Tr. Rubrum	5	4			1
Total	7	5			2

NOTE: Most of the nail, cutaneous and groin cases were not "purely" one or another, but chiefly so.

TABLE II

ADDENDA

Since completing the main body of this paper additional information has been collected, somewhat changing this writer's outlook regarding this drug. The number of cutaneous cases has increased to 80; scalp cases to 84.

Cutaneous and Nail Cases

The only additional cures have been 5 groin cases, of short duration, making a total of 10 cures out of the 12 groin cases treated. Of the remaining 68 cutaneous and nail cases, 55 have dropped, or have been dropped, from observation, without a single cure after four to 15 months of continuous treatment, and 13 are still under treatment and observation. Of these 13, 9 are veterans with extensive cutaneous and nail ringworm, and all have been treated over a year, with improvement in some, but not one cure. (This fact will be alluded to in conclusions).

Scalp Ringworm (Massive Dosage Method)

After reading the article by Drs. Kirk and Verlin in the May 1960 *Archives of Dermatology*, and after a conversation with Dr. Clarence Livingood at about the same time, it was decided to try the massive dose technic.

Eighty-five children, 80 with M. Audouini, and 5 with T. Tonsurans infections, have been treated. The procedure followed has been to give during an eight-hour period, in divided doses, a total dosage of the drug amounting to approximately 0.5 gms. per 10 pounds of body weight. Instructions are given to clip the scalp in about three weeks and to return in 30 days. At the second visit the first massive dose is repeated, with instructions to clip and return in another month.

Of these 85 children, 70 have been observed a month after having received the second dose and are definitely cured. Another 5 have been observed a month after their first dose, and show marked improvement and have received their second dose. Ten have been lost to observation, the usual private practice percentage.

No known reactions have come to attention, except a transitory hive-like eruption in one child, three days after receiving his massive dose.

Revised Conclusions

After using griseofulvin for 18 months in a total of 80 cutaneous and nail cases, and 139 scalp cases this writer has formed some fairly definite opinions—about as follows:

1. The drug is still in the investigational stage. Its recent and present widespread use will result in disappointment to patients and physicians alike. It is no easy cure or easy answer to the problem of ringworm.

2. For ordinary ringworm of the skin, nails, buttocks, palms and soles, improvement usually follows use of this drug, but cure is very much the exception. In ringworm of the groin, however, particularly if recently acquired, cure seems to be fairly frequent.

It is felt to be significant that of the 13 cutaneous cases (groin excepted) who "followed through" for a long period of treatment, 9 are veterans receiving treatment at no expense to themselves. Most of these veterans would undoubtedly be among those who dropped out, had each been compelled to spend several hundred dollars for the treatment he received.

3. Scalp ringworm seems likely to be the one category wherein this drug gives promise of being of real and predictable value, especially if the "massive dosage" method is used. Many more scalp cases will have to be treated, however, before final conclusion is reached. It seems probable now that one massive dose will usually result in cure. This writer has now definitely discontinued x-ray epilation.

4. To this writer the most interesting part of this study has been the disproportion between the results observed and the ballyhoo which accompanied the early use of this drug. The collection of newspaper and magazine clippings (most

indicating rapid and complete cure) brought in by eager patients—make an interesting exhibit. Many physicians have made many very optimistic statements, and have written articles wherein the results reported have not been confirmed in any degree by this study.

It is the feeling of this writer that griseofulvin will probably remain a limited use drug, but that much more clinical experience is required before any lasting appraisal can be made. ◀

504 Broadway
Gary

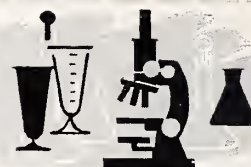
Mycological examination and cultures by Ona R. Whitley, Senior Bacteriologist and Mycologist, Indiana State Board of Health, Indianapolis.

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Much valuable assistance in the care and management of the scalp cases, and in the preparation of this paper, was rendered by Mary Louise Chiabai of the writer's office.

Griseofulvin, marketed as Fulvicin—used in this study, was provided in part by Dr. G. Kenneth Hawkins, Department of Clinical Investigation, Schering Corporation, Bloomfield, N. J.



The Qualified Medical Technologist: 'M.T. (ASCP)'

THE MEDICAL TECHNOLOGIST is probably called upon more often than any other member of the modern medical team that provides the physician with diagnostic procedures and other tools of information necessary to care for his patients. In spite of the extreme importance and necessity for great accuracy in the work the medical technologist performs, it is surprising that so little is known by the medical profession in general as to what constitutes proper qualifications for medical technologists, how these were established, and how it is possible to identify a qualified medical technologist.

In the first two decades of the 20th century, laboratory medicine was in a very primitive but rapidly developing phase. The medical profession in general, however, failed to recognize the full importance of the work of the medical laboratory until after World War I. Many physicians in the Armed Forces came back to civilian life with a real appreciation of laboratory medicine and its potential importance in peacetime medical practice. Among these returning physicians were those who had been active in the organization and conduct of medical laboratory services in the Armed Forces. Several of these young men, together with a few pioneers who had been building up medical laboratories in this country, met in 1922 and formed the American Society of Clinical Pathologists. One of their first problems was that of obtaining adequate technical assistance in the laboratories under their direction, and three years later they formed a committee to investigate this important matter.

Certification Begins

In 1928 the recommendations of this committee were accepted and a standing committee of the association was directed to undertake certification of medical laboratory workers who met

a set of minimum requirements for working in the medical laboratories of those times. This committee was called the Board of Registry of Laboratory Technicians of the American Society of Clinical Pathologists, and soon after was renamed the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists. It was empowered to issue certificates of qualification to those who met the requirements and to hold examinations on the basis of which certification could be carried out.

It soon became necessary to identify schools in which medical laboratory workers could receive training according to acceptable standards. This was undertaken by the same Board, and the first list of Approved Schools of Medical Technology was issued in 1933. In 1936 the Council on Medical Education and Hospitals of the American Medical Association, at the request of the Board of Registry, undertook to inspect the schools of medical technology in the process of their inspection of hospitals for internships and residencies. This program of inspection and approval through the Council was interrupted by the war and the service has not been carried out by the Council since that time.

In 1949 the American Society of Clinical Pathologists, recognizing the increasing need for careful supervision and coordination of the growing number of schools of medical technology, created the Board of Schools of Medical Technology as another standing committee of the American Society of Clinical Pathologists. This Board has worked in cooperation with the Council on Medical Education and Hospitals of the American Medical Association to inspect schools and issue lists of those which meet the requirements. This list is published each year by the Council on Medical Education and Hospitals. There are now over 750 approved schools.

Higher Standards

Since 1929, when the first applications for certification as registered medical technologists were accepted by the Board of Registry, the demands on the skills of medical laboratory workers have rapidly increased with advances in medical sciences, and as a result the Board of Registry, and subsequently, the Board of Registry in collaboration with the Board of Schools of Medical Technology, has gradually increased the requirements to meet the growing demands. At first, only high school graduation followed by 12 months of technical training by apprenticeship or in an approved school of Medical Technology was required. The most recent change in the gradual increase in requirements is that which sets the college requirements at three years, including special courses in sciences, followed by one year of approved school training. These requirements will go into effect Jan. 1, 1962. In most cases this results in the medical technologist obtaining a degree in medical technology from the college or university in which the 3-year college work has been taken, the fourth year being the year in the approved school, which is practically always acceptable to institutions of higher learning in lieu of the senior year of college.

Following termination of the 12-months' training in the School of Medical Technology, the prospective medical technologist takes a national examination conducted by the Board of Registry of Medical Technologists. Those who are successful are issued certificates by the Board identifying them as having met the qualifications for certification. They are then permitted to use the designation M.T. (ASCP) after their names, and this positively identifies them as having had proper training and having met all requirements for certification according to standards of the Board of Registry of Medical Technologists.

Substandard Workers a Hazard

Unfortunately, as in the case of all high attainments, there are many who would attempt to enter the field of medical laboratory work without acquiring all of the necessary training, and these substandard workers are a constant source of hazard to the practicing physician who fails to recognize the difference between a properly qualified worker and one who has failed to meet these qualifications. Therefore, it is of

great importance that all physicians know how to identify a qualified worker and how to recognize the unqualified person.

The difficulty in identifying a qualified worker if the above facts are not known may be considerable, since organizations issuing spurious certification exist in many parts of the country. There are, also, many so-called schools of medical technic conducted for commercial reasons, which may give as little as a few weeks of training and in which training may be of a very inferior and unacceptable type. It is often impossible for a physician whose field is not that of pathology to identify unqualified schools or unacceptable certification, and it is unfortunate that in many cases physicians are deceived into accepting the work of laboratory workers whose competence leaves much to be desired.

Another problem is that of giving young people who are interested in medical technology good advice as to where to obtain training. All too frequently a young person is advised by her family physician to enter a school which has been widely advertised, or which has a name which suggests high qualifications, and when the student has completed training, he finds that his education is not acceptable according to medical standards. Fortunately most universities, colleges and high schools are able to give students proper advice, so these are usually dependable sources of information. Lists of Approved Schools of Medical Technology may be obtained from the Registry of Medical Technologists.

Never Meet Demand

As the demand for laboratory workers increased, the number of schools giving this training has grown and output of the schools has risen gradually until in 1960, the school capacity was 5,753 and 2,452 medical technologists became certified. The demand, however, increases and the number of young people entering this field has never met the national demand. This, of course, creates a situation in which unqualified workers are all too frequently employed when qualified workers are not available. A national campaign for increasing the number of medical technologists has been carried on for several years by the American Society of Clinical Pathologists and the American Society of Medical Technologists, which is the national organization of qualified medical laboratory

workers. It is hoped that encouragement may produce enough qualified workers to meet most of the nation's needs. It is also the duty of the medical profession in general, and every physician in particular, to help in this recruitment effort, since all physicians benefit by having our medical laboratories staffed by medical labora-

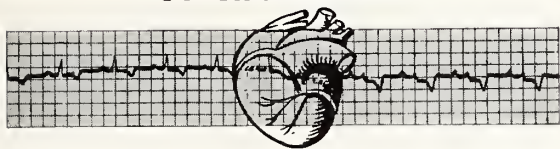
tory workers of the highest possible competence. ◀

Lall G. Montgomery, M.D., Chairman
Board of Registry of Medical
Technologists of the American Society
of Clinical Pathologists
Muncie, Indiana

New Pathology Forum

The Pathology Information Committee of the Indiana Association of Pathologists will conduct a "question and answer" column in the Pathfinder section of The Journal. Queries in the fields of anatomic or clinical pathology may be addressed to The Journal, 1019 Hume Mansur Bldg., Indianapolis 4. Answers and discussions will be published periodically.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Artifacts Simulating Atrial Arrhythmias

CHARLES FISCH, M.D.*

Indianapolis

ELECTROCARDIOGRAPHY is a laboratory procedure with a high degree of freedom from error as well as a remarkable reproducibility, provided the proper technic of recording is meticulously adhered to. In spite of all precautions and experience of the technician certain artifacts are unavoidable, and with these, the electrocardiographer must be familiar. Artifacts simulating disturbances of supraventricular rhythm should be suspected when: (1) with appearance of the arrhythmia there is no change in the pattern of ventricular response and/or (2) there is no defineable relationship between the atrial and ventricular complexes.

Case 1 (Figure 1): This tracing was recorded by the author himself. The tracing shows basically normal S-A rhythm and an intraventricular conduction delay with ventricular premature beats. In the course of recording lead V-2, "atrial fibrillation" appeared, the latter disappearing

with reapplication of the suction electrode. That the change is an artifact should be suspected immediately because there is no disturbance pattern of response of the ventricles on their rate. The R-R distance remains quite regular and measures the same as when P waves are identifiable. In addition, the compensatory pause following ventricular premature beats during "atrial fibrillation" and when normal rhythm is present is identical.

Case 2 (Figure 2): This tracing was obtained on a patient with Parkinson's disease with a most pronounced tremor in the left arm. The artifact, because of its regularity in leads I, III, AVL and AVF, all of which have the left hand as one of the connections, suggests atrial flutter. Failure to demonstrate a relationship between the respective "flutter" wave ("F"-R interval) and the succeeding ventricular complex should make one suspicious of an artifact. The very unlikely possibility of an A-V dissociation with atrial flutter remains, the diagnosis being excluded by presence of P waves in lead II, and availability of history of Parkinson's disease. Furthermore, the ventricular rate of 75, record-

*From the Robert M. Moore Heart Clinic, Marion County General Hospital.

Supported by the Herman C. Kraunert Fund of the Indiana Heart Association, the Indiana State Board of Health, Indianapolis, and the National Heart Institute (H.T.S. 5363).

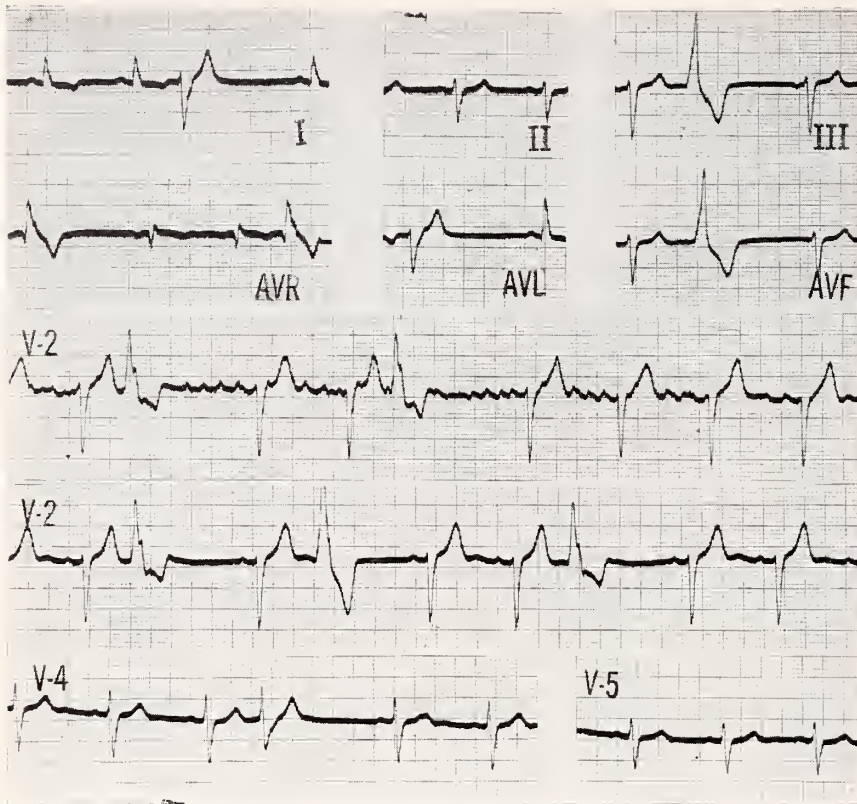
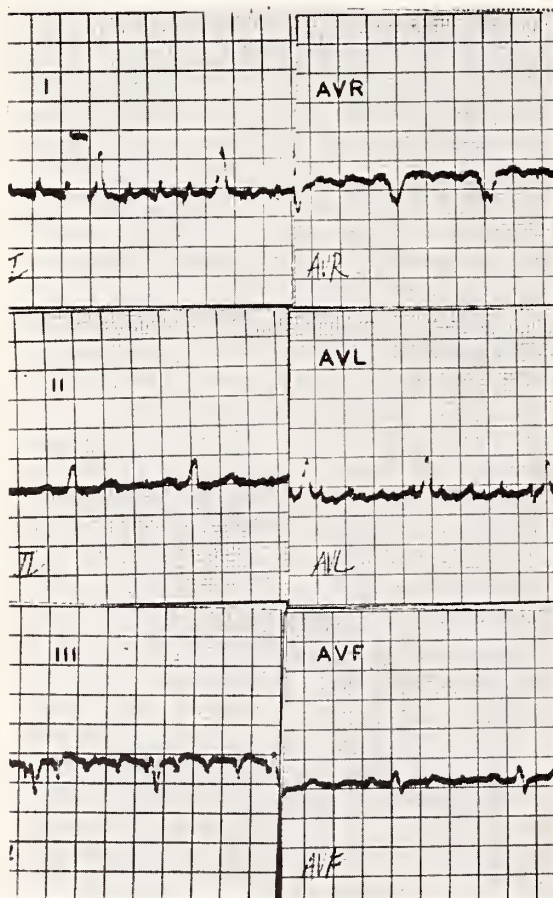


FIGURE 1.

THIS EKG SHOWS normal sinus rhythm. QRS measures 0.11-0.12 seconds, indicating intraventricular conduction defect. The R-R distance is approximately 0.92 seconds. Ventricular premature beats with a coupling of 0.58 seconds are also present. First part of V-2 shows an undulating baseline strongly suggestive of atrial fibrillation. Measurements of ventricular complexes, however, show an R-R, and the coupling distance to be the same as when P waves are identifiable, namely, 0.92 and 0.58 seconds respectively. This rules out an atrial arrhythmia and indicates an artifact.



ed in this tracing, seems too fast for a passive and too slow for an active lower A-V nodal pacemaker and again there is no difference in the R-R intervals of the leads recording "atrial flutter" and those recording normal sinus rhythm.

FIGURE 2

THIS TRACING shows an undulating baseline with regularly spaced waves, strongly suggestive of atrial flutter. For details see text.

Preferences of Indiana Physicians Regarding Postgraduate Courses in Psychiatry

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PERIODICALLY THE DEPARTMENT of Psychiatry of the Indiana University School of Medicine, in cooperation with the Indiana Department of Mental Health, has provided postgraduate courses to Indiana physicians. These have included "road shows," case presentations and discussions in communities distant from Indianapolis and more formal lectures at the Indiana University Medical Center. The postgraduate program of the Department of Psychiatry is being expanded, and several postgraduate courses will be offered each year.

Recently, the Postgraduate Training Planning Committee conducted a survey of Indiana physicians to determine the areas of greatest interest to physicians in the field of emotional and mental disorders. The committee felt that by learning the interests of Indiana physicians it would be in a better position to offer a more meaningful program suited to the needs of practicing physicians.

Preliminary Survey

A questionnaire was designed to help the committee determine psychiatric topics of choice of

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This Survey, and the postgraduate courses in psychiatry being given, are supported in part by Training Grants No. 9402 and No. 7282 from the National Institute of Mental Health, United States Public Health Service.

Indiana physicians, and in addition to ascertain any preference as to type of presentation, geographical location, day of the week and even time of day.

In February, 1960, a sample questionnaire was sent to 300 Indiana physicians selected at random by a mailing firm. Responses were received and tabulated from 85 physicians; a 28% return. Based on this experience, minor alterations were made in the final questionnaire.

Response to Survey

The revised questionnaire was mailed to 3,313 additional Indiana physicians in June and early July of 1960. 545 physicians responded (16.5%), resulting in a total response from 630 physicians, or 17.4%. The difference in the percent response to the two mailings may have been due to seasonal factors, physicians preparing for, or being on, vacation during the time of the second mailing, thus reducing the number of responses.

Questionnaires were returned from 77 of the 92 counties in Indiana. The counties from which no returns were received were Benton, Crawford, Decatur, Floyd, Franklin, Jasper, Martin, Ohio, Orange, Owen, Perry, Pike, Scott, Tipton and Washington.

Results of Survey

Returns from the final mailing were found to confirm preferences observed in the preliminary one. The results were applied immediately and

RANKING	SPECIAL INTEREST IN:	PRACTICE LIMITED TO:	CERTIFICATION IN:
1	Obstetrics and gynecology	Internal medicine	Pediatrics
2	Psychiatry	Pediatrics	Internal medicine
3	Internal medicine	Psychiatry	Psychiatry
4	Pediatrics	Obstetrics and gynecology	Obstetrics and gynecology
5	Surgery	Surgery	Surgery

TABLE I

are being reported here as a matter of information to the medical profession:

Type of practice reported:

Engaged in the general practice of medicine -----	418
Having a special interest in a particular field of medicine -----	172
Practice limited to a specialty -----	222
Certified -----	131
Not in the private practice of medicine. Majority of time spent in:	
Intern or resident -----	15
Institutional practice -----	30
Administration -----	6
Education -----	1
Public Health -----	5
Retired -----	8

The numbers shown do not add to a total of 630 because of the overlap between items.

The five fields of medicine represented by the largest numbers of physicians who reported a special interest, limitation of practice, or certification are listed in Table I in descending order.

Preference as to content of postgraduate courses in psychiatry: The 25 topics given in Table II are listed in the order in which they appeared on the questionnaire. Each physician was requested to circle the numbers in front of each of the 25 topics in which he would be interested. The 630 physicians returning the questionnaire indicated varying degrees of interest in topics—389 physicians expressed an interest in topic number 2; 62 physicians expressed interest in topic number 25 by naming additional subjects. The rank of each topic, based on the numbers of physicians indicating an interest in it, is shown in the first column to the right of each topic. The number appearing in the second column to the right of each topic indicates the weighted rank of the topic, as described later.

The additional subjects suggested by the 62 physicians taking advantage of topic number 25

were varied. The additional subject suggested by the largest number (11) concerned hypnosis. Other suggestions included such topics as neurophysiology, neurochemistry, use of general hospitals, psychological testing, heredity, and suggestions concerning various aspects of the 24 topics named.

First Five Choices of Topics

Each physician was requested to list by topic number his first five choices of the topics in which he had indicated an interest.

In tabulating these first five choices, a weighted scale was used. The committee assigned a value of 5 to each topic listed as a first choice, a value of 4 to each topic listed as a second choice, down to a value of 1 for each topic listed as a fifth choice. In other words, a "first choice" was felt to be five times more significant than a "fifth choice."

Following are the first five choices so weighted:

Choice	Topic
1st	Drug Therapy in mental and emotional disturbances.
2nd	Technics of short-term psychiatric treatment.
3rd	Psychosomatic conditions, such as peptic ulcer, ulcerative colitis, asthma, headache, back pain, etc.
4th	Interview technics for usual as well as for difficult situations.
5th	Adolescent behavior problems.

Given in Table II, in the second column to the right of the 25 listed topics, is the weighted rank for each.

Based on these results, the Department of Psychiatry presented courses in drug therapy and technics of short-term psychiatric treatment at both Logansport and Columbus in October 1960; courses concerning psychiatric aspects of certain physical disorders at Fort Wayne and Evansville in April 1961; and a course in child psychiatry at the medical center in June, 1961.

TOPIC NUMBER		RANK BY NUMBER OF PHYSICIANS EXPRESSING AN INTEREST	WEIGHTED RANK
1	Technics of short-term psychiatric treatment.	4	2
2	Drug therapy in mental and emotional disturbances.	1	1
3	Interview technics for usual as well as for difficult situations.	11	4
4	Mental retardation.	22	23
5	Adolescent behavior problems.	5	5
6	Emotional concomitants in medical and surgical conditions.	18	13
7	School problems.	17	15
8	Childhood behavior problems.	6	8
9	Psychosomatic conditions, such as peptic ulcer, ulcerative colitis, asthma, headache, back pain, etc.	2	3
10	Role of the physician in follow-up of released psychiatric patients.	15	17
11	Accident-prone patients.	23	22
12	Care of the geriatric patient.	13	10
13	Depression and the suicidal risk.	8	12
14	Alcoholism.	14	16
15	Drug addiction.	24	25
16	Obesity.	3	7
17	Handling of psychiatric emergencies.	7	6
18	Procedures of commitment, admission, and discharge of psychiatric patients.	21	24
19	Juvenile delinquency (the early manifestations, and technics for later management).	20	20
20	Early manifestations of schizophrenic disorders.	10	9
21	Emotional problems of the involutional period.	16	19
22	Medicolegal problems (court testimony, medical responsibility, etc.).	19	18
23	Premarital counseling.	12	14
24	Marital counseling.	9	11
25	Others (name as many subjects as you choose).	25	21

TABLE II

Additional topics will be covered in several courses to be held during the next, and subsequent, academic years.

Preferred times for holding postgraduate psychiatric courses were indicated by placing an "x" in the first and second choice columns. The results are as follows:

First Choice Second Choice

222	65	Two full days at one time.
59	28	One morning each week for four consecutive weeks.
70	59	One afternoon each week for four consecutive weeks.

97	106	One evening each week for four consecutive weeks.
56	89	Dinner meeting one evening each week for four consecutive weeks.
92	175	One full day a week for two consecutive weeks.
9	12	Other.
25	96	No choice given.

Day(s) of week preferred were indicated by placing an "x" in the first and second choice columns. The results are as follows:

<i>First Choice</i>	<i>Second Choice</i>	
26	62	Sunday
24	27	Monday
49	74	Tuesday
202	100	Wednesday
123	116	Thursday
20	59	Friday
20	43	Saturday
33	123	No choice given

Of the 222 physicians who gave as first choice "two full days at one time," 133 went on to indicate the two days they preferred. More than 53% preferred a Wednesday-Thursday combination. From this, and from the above results as to days of the week preferred, it is evident that Wednesdays, Thursdays, and Wednesday-Thursday combinations are the days overwhelmingly desired.

The days of the week preferred were correlated with county of residence as an aid to the committee in selecting the day(s) in which courses should be held in a given area.

Month of the year preferred was indicated by placing an "x" in the first and second choice columns. The results are as follows:

<i>First Choice</i>	<i>Second Choice</i>	
67	18	January
42	55	February
46	49	March
65	41	April
69	53	May
39	40	June
28	30	July
7	19	August
66	34	September
66	92	October
41	77	November
8	20	December
86	102	No choice given

Geographical area of the state in which courses should be held was indicated by placing an "x" in the first and second choice columns. The results are as follows:

<i>First Choice</i>	<i>Second Choice</i>	
74	34	Northwest part of the state.
75	48	Northeast part of the state.
64	111	North central part of the state.
309	188	Indianapolis.

34	33	Southwest part of the state.
18	11	Southeast part of the state.
25	46	South central part of the state.
31	159	No choice given.

The geographical area preferred was correlated with county of residence of the physician. With few exceptions, physicians preferred having the courses held in the geographical area of the state in which they resided. A notable exception pertained to the preference for holding courses in Indianapolis. The majority of physicians in 33 of the 77 counties responding preferred Indianapolis. These counties included some as far north as Miami, as far south as Clark, east to the Ohio border, and west to the Illinois border.

Type of meeting place was indicated by placing an "x" in the first and second choice columns. The results are as follows:

<i>First Choice</i>	<i>Second Choice</i>	
97	104	General hospital.
85	99	Hotel.
50	54	Country Club.
57	104	State hospital of district.
281	138	Indiana University Medical Center, Indianapolis.
13	5	Other.
47	126	No choice given.

Method of presentation was indicated by placing an "x" in the first and second choice columns. The results are as follows:

<i>First Choice</i>	<i>Second Choice</i>	
118	118	Case demonstrations.
278	118	Lectures.
89	157	Panel discussions.
90	102	Seminars (open discussions).
17	71	Films and slides.
8	3	Other.
30	61	No choice given.

Comments were made by 114 of the 630 physicians responding. These were informative, constructive and of great value to the committee.

The committee expresses its appreciation to the physicians who made this survey possible. It welcomes continuing comments and suggestions from all Indiana physicians in order to meet better the needs and interests of physicians in postgraduate courses in psychiatry.

Summary

In expanding its postgraduate training program, the Department of Psychiatry of the Indiana University School of Medicine, in cooperation with the Indiana Department of Mental Health, surveyed Indiana physicians to determine their choice of psychiatric topics, type of presentation, geographical location, month, day of the week and even time of day.

A questionnaire was sent to 3,613 Indiana physicians; 630 physicians responded, or 17.4%. Questionnaires were returned from 77 of the 92 counties in Indiana.

The first five choices of psychiatric topics were drug therapy, technics of short-term psychiatric treatment, psychosomatic conditions, interview technics and adolescent behavior problems.

Most physicians responding indicated that courses should be held two full days at one time; one full day a week for two consecutive weeks; or one evening a week for four consecutive weeks.

Wednesdays, Thursdays, and Wednesday-Thursday combinations were the days overwhelmingly desired.

The months of January, April, May, September, and October were selected, and to a nearly uniform degree.

With few exceptions physicians preferred that the courses be held in the geographical area of the state in which they resided. A notable exception pertained to the preference for holding courses in Indianapolis. The majority of physicians in 33 of the 77 counties from which responses were received preferred Indianapolis.

Similarly, the majority of physicians preferred that meetings be held at the Indiana University Medical Center.

The methods of presentation most preferred were lectures and case demonstrations.

Comments were made by many of the physicians responding. These were informative and constructive. Continuing comments and suggestions are solicited. ◀

DON'T DELAY IN MAKING RESERVATIONS . . .

112th Annual Convention

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Hats Off to the British

IN SPITE of the doubtful status of British medicine in the socialized form, something must be said in favor of the manner in which they are handling the problem of increasing drug costs. This, especially in view of a slight tendency on this side to legislate the prescribing of cheap drugs and to eliminate the financial protection afforded by patents.

The Ministry of Health is embarking on a plan to purchase drugs from non-British firms, and even from firms manufacturing patented drugs without a license from the patent holder. Drugs from a non-British manufacturer who does not pay any royalty to the owner of the patent would of course be lower in cost.

The significant bit in the transaction is that in every case when drugs are bought from a source which is not the holder of the patent, or a licensee to manufacture under the patent, the government will reimburse the patent holder to whatever extent he is entitled under the British Patents Act.

The British Medical Journal, May 27, 1961,

in an editorial quotes the Health Ministry as stating "The importance of patent protection for the development of the British pharmaceutical industry and for the encouragement of research is fully recognized by the Government, who do not believe that these objects will be prejudiced."

Later in the same editorial the question of steadily mounting hospital drug bills is discussed as follows: "The increasing cost must be largely due, as it doubtless is in general practice, to the continual introduction of new drugs, which are necessarily more expensive at first. Whether they are more efficacious as well as more expensive than their predecessors is another matter. The way to test this is to try them by the stringent procedures that have become traditional in the best centres here. There are obvious dangers in pursuing a policy of discouraging their introduction at all."

Despite its adherence to the socialized method, the British Ministry of Health has some advantages over a certain segment of our own federal government. It realizes the importance of the patent system in the development and

introduction of new drugs. It is determined to continue the financial advantage of that patent system for its own pharmaceutical industry.

If, God forbid, our patent system as it relates to drugs is destroyed and the research which

leads to new and improved drugs is eliminated, Americans may take heart in the fact that, at least for the time being, the British pharmaceutical industry will be continued with common sense and on a productive basis.

Most Versatile Doctor—the GP*

THE “HALO” attaching to the physician is largely due to the “family doctor” of past generations, who is still represented by the general practitioner.

Excessive medical specialization and the “hospitalitis” frenzy have cracked that “halo” and stimulated many malpractice suits, the Forand Bill, etc.

The GP is still the main hope of future private medical practice and the restoration of the “halo.” The GP better understands both the patient and his family background. He is more familiar with the social and civic life of his patients, all of which now enter into successful treatment.

Each week 20,000,000 patients consult doctors. Of these 20,000,000, it is conservatively estimated that 10,000,000 (50%) have NO DIAGNOSABLE PHYSICAL AILMENTS WHATSOEVER! They are “worry warts.”

Their pains are often psychosomatic, based on marital feuds, worry over an erring son or daughter or too much tension trying to “keep up with the Joneses.”

The GP detects these background factors because he has the broader acquaintance with his patients; his insight is superior.

The GP can also become a great boon to the taxpayers, for our hospitals are now so glutted with unnecessary patients that there is a constant clamor for more and bigger hospitals—all at the taxpayer's expense.

If the medical insurance companies would cooperate more fully with the GP, we could partially empty present hospitals and thus eliminate the need for more taxes to build additional hospital facilities.

Thus, the insurance companies should insert a \$50 or even a \$25 deductible clause. This would

slow down the mad epidemic of “hospitalitis,” where patients race to a hospital even for a blood count and urinalysis, as well as x-ray therapy.

It would also prove an additional blessing for the insurance firms to allocate their payments to cover all the services rendered in private medical offices.

In brief, much of the present hospital service to patients was formerly performed quite creditably in the private offices and laboratories of the GP. Patients should again learn to go to the GP for such check-ups, instead of thinking they can only obtain this phase of medical treatment in the glorified “cathedrals of healing,” otherwise labeled as hospitals.

When the former “halo” rested on the brow of the doctor, it was due to the family physician who seldom needed hospitals. The acute surgical and medical cases were relatively of secondary importance as regards the overall medical picture.

Hospitals were then figuratively the “tail” on the “dog” of medical practice. Now, alas, the private physician has been relegated to that caudal appendage and hospitals are getting the spotlight.

Beware, for as soon as the general public begins to worship massive buildings and kow-tows to “institutionalized” medicine, then it will be but a short step till people bow down toward the East and the Great White Father in Washington.

Socialized medicine will then usurp the respect of the family doctor. The Cancer Foundation, the U.S. Public Health Dept., etc. will dominate.

Medicine is still a matter of MEN—not buildings, even of the latest glorified hospital variety!

And the GP is the type of physician who still feels the pulse of both the individual patient

* Excerpts from an address delivered at the annual meeting of the Indiana Academy of General Practice, March 16, 1961, Indianapolis.

and our body politic. He is the "grass roots" doctor.

It is now time for the GP to assert his dominance of foundations, hospitals and the entire practice of modern medicine, both for the sake of future private practice of medicine and the greater welfare of the public.

"Hospitalitis" is rapidly reducing the prestige of medicine by making doctors simply glorified attendants at huge healing centers. They rate little better than white-coated lab technicians and other hospital attendants.

So the GP has the Herculean task of freeing

the profession of medicine from institutional control, federal regimentation and a growing public disrespect due to "assembly line" impersonal treatment.

It is the GP, when supported by the medical insurance companies, who can partially empty our glutted hospitals of the neurotic patients, who need to be sent back to the versatile "family doctor." It is his understanding treatment that again will enshrine the medic as something more than a laboratory researcher or white-coated ancillary of massive hospital architecture.

—George W. Crane, Ph.D., M.D., Chicago

Threat of Divide and Conquer

I WONDER WHY, when our lives and our social philosophies and institutions are being assailed by advocates of socialism, statism, or government control, we physicians and the hospitals are continually bickering about who shall be in command of the medical care of our people.

I wonder why hospital boards and administrators, along with representative national groups, continue to view physicians in alarm, while we reciprocate in a like manner.

I wonder how a hospital with modern equipment, staffed with excellent personnel, can engage in petty quarreling over privileges and rights when the common goal is to care for people seeking to regain their mental and physical health.

I wonder how physicians could practice their art without the physical structure of hospitals, and how hospitals could operate without the knowledge and skills of physicians.

I wonder if more open discussion by unselfish men with broad vision would lead to a better understanding and more efficient use of both hospitals and physicians.

I wonder what the consumer thinks of our petty bickering over the rights of free choice; our fees and our hospital privileges.

I wonder if the internal strife among our surgeons and all of their classifications; our internists; our general practitioners; etc. is for healthy competition when we are all needed cogs in the medical machine.

I wonder why we can't police our own admissions and lengths of stay in the hospital, and not have it done for us by outside agents.

I wonder about the Hospital Association through Blue Cross being given the authority to limit admission to a predetermined length of stay, depending on the admitting diagnosis.

I wonder about the Hospital Association through Blue Cross wanting the authority to limit coverage for new additional beds unless they have passed on the need.

I wonder why in every instance Blue Cross and Blue Shield cannot work together harmoniously for the good of all, since both have a specific place in the scheme of things.

I wonder if our criticism of movements and trends in medicine is well thought out or is just a quick and shallow conclusion motivated by personal gain instead of being what is best for the health of our nation.

I wonder how we will meet the new challenges of socialism, so contrary to our concepts of individual freedom and dignity, when we are being divided and conquered.

I wonder if we have been able, or have made sufficient effort as a whole or as individuals, to get our message to the consumer of our wares, or are we being so suspicious of each other that we do not see the vulture of socialism hovering overhead to devour the weakened victor.

I wonder if the human trait of greed and

selfishness motivates most of us, in both fields, to obtain wealth and power to the ultimate detriment of our consumer, the public.

I wonder if a step on our "economic toes" is not responsible for many of our explosive and thoughtless responses to a given situation.

I wonder if personality clashes, rather than mature judgments, activate many of our actions.

I wonder if medicine realizes that the forces of government, hospitals, labor unions and the public are all attacking our freedom and distorting our image to the detriment of all.

I wonder why Blue Cross can streamline benefits and premiums and present a united front while medicine through Blue Shield has many variations in premiums, eligibilities and benefits.

I wonder how much our unwillingness to listen

to logical arguments prevents us from changing our minds.

I wonder how much our lack of sympathetic understanding and thoughtlessness motivates the public to a rash of malpractice suits.

I wonder if we say what we think, or merely talk to camouflage our real intention.

I wonder if there will ever be a time when the sharp blacks and whites of our convictions will give way to some gray areas of compromise.

I wonder why, when faced with a common danger, we can work together and when that crisis is passed pick each other apart.

I wonder why President Kennedy's program excludes most physician's payments in proposed legislation, unless he seeks to divide and conquer.

—Walter L. Portteus, M.D., Franklin, Ind.

Editorial Notes

The Food and Drug Administration recently published a preliminary guide to manufacturers and shippers of hazardous household chemicals. It consists of definitions and information necessary for compliance with the Federal Hazardous Substances Labeling Act. Regulations will be published later. The Act was passed in July, 1960. When it is fully implemented it will specify and control the labeling of all dangerous household chemicals of which there are an estimated quarter million at present. Proper and informative labeling will contribute to a decrease of the some 600,000 cases of injury due to such substances annually, and the annual death toll of around 50.

Is there a possible correlation between the facts that women live longer than men and even though they suffer significantly more acute illnesses they invariably restrict activity longer and rest in bed longer than men for each illness? *The Health Insurance News* points out that women have acute conditions at the rate of 224 per hundred while men have a rate of only 205 per hundred. On the average the ladies were restricted in activity for 9.4 days per illness in contrast to man's 7.5 days. Also on the average women were treated by bed confinement for 4.0 days; the male average being 3.2 days.

Professional nursing schools admitted almost 2,000 more students in 1960 than in 1959.

Admissions to practical nursing instruction were increased by 278, to make a total of new students in both programs in 1960 of 73,565. The National League for Nursing also reports that the ratio of full-time professional nurses to the population is still too low. There are now 231 full-time nurses per 100,000 population; 300 per 100,000 is considered a minimum essential figure.

The Fourth of July weekend in 1960 recorded 442 persons injured fatally in traffic accidents. Careful investigation has disclosed that not a single one of the fatalities was protected by a seat belt. Statistics show that 42% of all persons killed in cars could be saved by seat belts. Newspapers should be encouraged to report on the presence and usage of seat belts when an auto accident is written up.

Homes for elderly people are not always as safe from fire hazards as they should be, says Detroit Fire Marshal Glenn E. Thom in a report to the National Fire Protection Association. Many elderly patients living in custodial homes such as nursing homes, boarding homes or special hotels are so feeble that they are unable to care for themselves in an emergency. Marshal Thom would like to see automatic sprinklers, alarm systems, proper exit facilities and special training for the staff people who care for them. Safety standards on a national scale would be a step forward, too.

President's Page

CONCERNING FEE-FIXING

One certain way for physicians to promote socialization of their profession is to overcharge their patients. This fact, long recognized, does not, however, lend itself to an easy remedy. Many panaceas have been suggested: "service plans" under voluntary insurance schemes, the San Joaquin County plan, the closed panel systems and myriad other sugar-coated solutions, none of which are enforceable because of the simple escape hatch of non-participation, either by the patient or the physician.

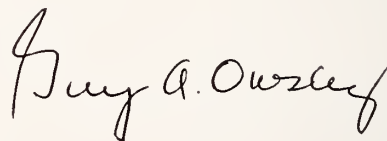
Now comes a threat which may eventually oblige us to do away with any fee-fixing mechanism because of the legal implication that it is the root of limited competition.

In the June 13 edition of *Wall Street Journal* the headline of an article proclaims that "California Acts to End Alleged Fee-Fixing in Professions." Named specifically in the article are realtors, engineers and lawyers who sell only their services. But the article continues—"although lawyers' fees, like those charged by DOCTORS and DENTISTS, vary widely from suggested schedules. California's Antitrust office has heard a few complaints of pressures from local bar associations to enforce some fees." "We would certainly take action if we received any formal complaints," the Assistant Attorney General stated.

What is the legal implication of this maneuver? Simply stated, it is reasonable to assume that ANY fee-fixing scheme by a trade association or an organized professional group MAY come under the scrutiny of the trustbusters and if that be the case, and if found guilty as charged, the best argument for an indemnity system of coverage will have been made.

We, in Indiana, have argued long and loud that if the physician is true to himself, if he doesn't gouge the patient, if he operates in the knowledge that his best results are built around good doctor-patient relationship in pre-arranged discussions of fees as well as the professional problem involved, he will have nothing to fear from socialism based on disgruntled patient attitudes, and in actual practice he doesn't need the hidebound objectives contained in a fee schedule.

These, my friends, are the reasons we maintain an indemnity plan of coverage in Indiana, and if we continue to improve our behavior there will be no need to fear the trustbusters, the socializers or anyone else.



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Facts Are Stubborn Things

FRANCIS BOYER*

Chairman of the Board

Smith Kline & French Laboratories

STARTING WITH the Kefauver hearings, the critics of our present system of medical care and of the pharmaceutical industry have urged that the physician prescribe by generic rather than by trade names. This he should do voluntarily, and if he will not do it voluntarily, he should be forced to, by some kind of government pressure, certainly in the welfare area.

If the doctor will only prescribe by generic name it is alleged that his patients (a) will save a *great deal* of money and (b) will get just as good medication as they would with brand name prescriptions.

I think that this is a fair summary of the case presented by the critics and it is my contention that the only trouble with it is, that both (a) and (b) just aren't so. They are both statements contrary to fact, and facts are stubborn things.

Let us therefore examine these two arguments for generic prescribing. First, how much money is the patient likely to save? Some estimates of the savings to be brought about by generic prescribing are simply fabulous, presumably based on much publicized comparisons of a few price tags of individual items. For example, one national magazine recently stated, "By asking your doctor to prescribe drugs by their standard chemical names where possible, rather than by brand names, you may cut the cost of your prescription by 50% or more."

Now possibly a case or cases could be found where savings do amount to "50% or more." But to imply that this is generally true is about

as misleading as to say you may win \$12,724 at the races by betting \$2 on the daily double. It is true that a few lucky bettors once actually did collect this amount. It was the payoff at Caliente on July 4, 1954, and one of the horses' names, by the way, was Slick Trick.

But what, in the palace of truth, is likely to be the real savings to the patient on generic prescriptions?

Study of Top-Sellers

Last summer I asked SK&F's Marketing Research people to give me a list of what they thought were the 20 largest-selling prescription specialties. Now of the 20, three were mixtures—and I know of no practical way of giving generic names to mixtures. But more important, of these same top 20 prescription items, 13 were patented and I can see little probability that generic name prescribing would cause any price reduction at all in the case of a patented item.

Expressed a little differently out of this list of 20 top sellers there were only four which had any even theoretical "generic equivalents" or where *any* saving was likely under generic prescribing.

This fact made the alleged 50% savings through generic prescribing look pretty doubtful, so we made a couple of studies, one was an actual field survey, of items which *were* available under both brand and generic names. In one of these, the generic prescriptions showed an average saving of 11% and in the other the saving was 12%.

Finally we made an estimate of the total picture, and concluded that, if universal generic prescribing were in force, the savings to the consumer would be somewhere between 2 and 7½%.

* Delivered at Eighth Annual Session Pharmacy's Public Health Forum, sponsored by Alumni Association, Brooklyn College of Pharmacy, Long Island University, April 12, 1961.

The cynic might suspect that this was a biased study made by a wicked manufacturer, so I'll now give you another study and here I quote from the *Rhode Island Medical Journal*, January, 1961:

"The (Rhode Island) Division of Public Assistance, examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings to the department of "generic" versus "trade-name" drugs. The drugs had cost \$28,000. Substituting generic drugs whenever possible would have provided a saving of *less than 5%* (\$1,400). Syracuse has made a similar study in drug costs with comparable results."

Somehow the 50% saving from generic prescriptions has evaporated down to five percent.

Question of Equivalence

So much for argument (a). Now let's turn to argument (b): that, with generic prescribing, patients will get just as good medication as they would with brand name prescriptions.

To begin with, what are the statements of unquestioned authorities as to just how equivalent many so-called generic equivalents actually are?

Dr. Lloyd C. Miller, Director of Revision of the USP, told the Kefauver subcommittee, with respect to generic name prescribing and dispensing: "My opinion, sir, is that it is unsafe because there is not sufficient policing of our standards at the present time."

Also in the Kefauver hearings, another witness, an associate professor of pharmacology, after censuring the industry for excessive promotion of brand names, under questioning admitted: "At present I would not be happy with a generic named drug if I did not know what company made it."

At the Convention of the American Pharmaceutical Association in 1959, Dr. Albert H. Holland, former Medical Director of the Food and Drug Administration, really nailed the thing down when he said: "The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. FDA labors long and diligently to protect the public, but the fact of the matter is that it is completely impossible for the FDA to check every batch of every product of every manufacturer that is marketed. Hence the

integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Now, these statements are perhaps mere opinions, though admittedly, they are the judgments of experts in the field. What *facts* can we bring to bear on the question?

Mr. H. L. Flack, Director of Pharmacy of Jefferson Medical College, reported to the 1959 convention of the Parenteral Drug Association on the results of a random sample of 15 purchases from different suppliers of ascorbic acid injection. His tests showed "almost one-half (47%) of this sample failed to meet the USP minimum standard."

Now let's call on FDA Commissioner Larrick. Before the Kefauver Sub-Committee Mr. Larrick testified that over a period of 10 years the Food and Drug Administration had to take action only four times against any of the 28 well-known companies that produce 87% of the nation's drugs, the vast majority of them under trade names. In sharp contrast, the FDA had to take 484 actions against 235 of the 1200 or so lesser-known companies that produce the remaining 13%.

A recent survey of SK&F offers additional evidence. Two of our prescription specialties were shopped in a statistically significant number of stores in several cities, roughly half of the prescriptions being written for the brand name and half for the generic name. When these drugs were analyzed, the active ingredient content of the so-called "generic equivalents" was found to fall outside the extremes of tolerance established by the U. S. Pharmacopeia in 35% of the cases, whereas all samples of the branded products were of top quality.

Samples Show Variation

Finally, the January 20 issue of the "Medical Letter," which heaven knows cannot be accused of unduly favoring brand name drugs, reported on a study of secobarbital capsules purchased from 36 different drug companies. Samples of capsules purchased from Eli Lilly, the principal brand-name manufacturer (Seconal) as well as those from 26 other companies, conformed fully to U.S.P. standards. Samples from the nine other companies failed to meet U.S.P. standards because of excessive weight variations; one com-

FACTS ARE STUBBORN

Continued

pany's product showed capsule to capsule variations of from -41% to $+40\%$.

Now what do these facts demonstrate in regard to the quality of generic drugs?

Unquestionably many products sold under generic names are of the highest quality. On the other hand, as these surveys show, an appreciable percentage are not. It is sad but true that some manufacturers of cheaper "generic name" products have neither the money, nor the skill, nor the facilities to make an effective product and to insure the quality of every batch produced. Quality control may require as many as a thousand tests from raw drug to finished product. Time and again it has been shown that the only real guarantee of a drug's quality is the integrity of the firm which makes it, and the trade mark, the brand name, is the pledge of that integrity.

As I said I would, I have tried to avoid side issues, and have stuck to an examination of the two main arguments advanced for generic as opposed to trade name prescribing. To me it

seems that very little is left of these arguments. The theory "equally good products at a great saving to the patient" remains a theory, in complete opposition to the facts, and once again facts are stubborn things.

This being so, it would seem obvious that most physicians will be reluctant in their normal practice to give up brand name prescribing. Their patients save very little money—Rhode Island says less than 5%—and they run an appreciable risk of getting sub-standard medication.

It follows, moreover, that any government effort to force the medical profession into generic prescribing is an effort to pressure the doctor into second rate medicine, and relinquish an essential prerogative of his calling, to determine exactly what medication he wishes his patient to receive.

If this pressure is applied to welfare prescriptions, giving the indigent alone a "drugs anonymous" system, it sets up a double standard of medicine, one for the carriage trade and one for the poor—with, as I have shown, mighty little savings to the state. ◀

Please note the following addition under "Professional Medical and Allied Organizations" in your June *Journal*:

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Officers for 1961

President ----- Guy A. Owsley, Hartford City
President-Elect ----- J. Lawrence Sims, Indianapolis
Vice-President ----- John M. Thompson, South Bend
Secretary-Treasurer ----- Lewis E. Morrison, Indianapolis
Editor of Transactions ----- Kenneth L. Craft, Indianapolis

Members of Council: Herschel S. Smith, Wallace K. Dyer, John J. Flick, Milton W. Erdel, Ernest L. Dietl, Charles L. Mahoney.

Your Cholesterol Depressant Diet Book

Menu plan for

Mrs. John Doe
DATE Feb. 1961

JOSEPH ROE

M.D.



1200 CALORIES		1600 CALORIES		1800 CALORIES	
breakfast	1 1/2 cup grapefruit sections	50	lunch	1 1/2 cup grapefruit sections	50
	1 fried egg	25		1 fried egg	25
	Coffee or tea with 3 drops, skim milk	15		Coffee or tea with 3 drops, skim milk	15
	TOTAL	90		TOTAL	90
snack	4 oz. tomato juice	25	snack	4 oz. tomato juice	25
	2 oz. drained tuna fish, surrounded with raw vegetables with 1 drop French dressing	50		2 oz. drained tuna fish, surrounded with raw vegetables with 1 drop French dressing	50
	1 1/2 water	25		1 1/2 water	25
	Coffee or tea with 3 drops, skim milk	15		Coffee or tea with 3 drops, skim milk	15
	TOTAL	115		TOTAL	115
dinner	(May be had at mid-afternoon or evening)		dinner	(May be had at mid-afternoon or evening)	
	6 oz. skim milk	50		6 oz. skim milk	50
	TOTAL	50		TOTAL	50
	TOTAL CALORIES FOR DAY	1765		TOTAL CALORIES FOR DAY	1765

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DR. _____

ADDRESS _____

CITY _____ ZONE _____ STATE _____

Tax Shavings

EUGENE P. CORNETT*

Indianapolis

TAXES! TAXES! TAXES! Everybody talks about how high they are, but how much are they doing to really keep their taxes to a minimum?

Let's talk about income for just a moment. If you were to make a million dollars in ordinary income, you would get to keep \$146,000 of this if you file your return jointly with your wife. If you were to make the same million dollars in the form of oil income, you would get to keep approximately \$375,000 on a joint return. If you were to make this million dollars from long-term capital gains, i.e., by investing wisely and making a profit, you would get to keep about \$750,000—so you can see by this comparison that you will never get rich by making ordinary income because of the escalating characteristics of our tax rates. The tax on a million dollar ordinary income, you can see, is \$854,000. Out of that last \$600,000 you are entitled to keep \$9,000 of each 100,000. Even with the tax rates as high as they are, however, it is a fallacy, and a common one, to think that one should spend the money just because it is tax deductible. Even in the 91% bracket you still have 9¢ left if you don't spend that dollar in the first place—so don't spend money just because it is tax deductible.

One of the most common tax savings which I am certain is not utilized to its fullest extent, is that of the Annual Dividend Exclusion. As some of you probably know, there is a provision in the tax law entitling each taxpayer in the United States to receive up to \$50 per year in

the form of dividend income without paying a cent of tax on this. Of course, if you and your wife own stocks jointly, you may exclude annually up to \$100 of dividend income. This is a rather small tax savings, but coupled with the others, it amounts to something. Normally speaking, an investment of about \$2,500 in a good blue chip dividend-producing stock will bring you dividends of \$100. Some of you might think this should be over and above your emergency fund, and perhaps it should be. It is just a matter of thinking. However, if you are dealing with a reputable brokerage firm, normally, you can obtain your money from the sale of stock within a four-day period. If it happens that the stocks you need to sell are down at the time, it isn't necessary that you sell them in order to raise funds. You can use them as collateral at the bank. The interest of course, on this loan will be tax deductible and then when the market is at the proper level, you can sell the stocks and pay off the loan. So it isn't necessary to feel that this money is tied up indefinitely. There are a few corporations who do not qualify for these dividend exclusion features, so you should check the particular stocks you plan on investing in for this particular feature.

Municipal Tax-Free Bonds

I would like to mention Municipal Tax-Free Bonds since I feel that a number of you have heard of this as an excellent way to produce tax free income. It is, in a sense, but in another sense it isn't too desirable. Sometimes when you buy tax-free bonds in order to get an excellent rate of return, you have to buy a bond that matures many years later. This may be unde-

* Presented before the annual meeting Indiana Academy of General Practice, March 15, 1961, Indianapolis.

sirable because, first of all, if you want your money in a hurry, you may have to sell at quite a discount just in order to liquidate your holdings. However, you may settle for a lesser rate of return and buy bonds that mature earlier.

Some thoughts should be given to maintaining a balanced portfolio of investments. By this I mean that the economy definitely has trends in certain directions. It is either heading for a recession, or it is heading for inflation. I am not talking about this in terms of the next few months, I am talking about it in terms of the next few years. Consequently, I think that current thoughts along this line are that we are headed for an inflation. At least Congress and the legislative bodies are busy, apparently, trying to produce an inflationary period. So in view of this situation, it would seem logical that we should have in our portfolio a number of common stocks since this is the best known way to protect the purchasing power of the dollar, stocks normally go right up with the economy.

If a sack of flour costs you a dollar today and you have that dollar and put it in a common stock, 10 years from now a sack of flour may cost you two dollars, but the same dollar you invested today is now worth two dollars, so you can still buy your sack of flour. If you put this dollar in a savings account and accumulate interest on it, you would not have the two dollars that it took to buy the sack of flour. Therefore, it is important that you carry the majority of your investments in a form that will ride along with a climbing economy. By the same token, it is equally as important that you carry a certain amount of your investments in a fixed dollar type investment whereby if we have a depression and a sack of flour costs 50¢, by proper planning you may have protected your dollars in a savings account or government bonds or some other fixed dollar investment medium, and at that time you will have 75¢ or 80¢ to buy the 50¢ sack of flour and, of course, this is a very opportune time to pick up bargains in the investment field if you just have the money.

Manipulating Holdings

Let's go a little further into this business of investing and see what some of the tax advantages are in manipulating your holdings. One of the ways this can be done is to review your portfolio just before the end of the year

and see whether you have any stocks that have gone down in value. You are entitled to deduct up to \$1,000 Net Capital Loss on your tax return each year. This can offset ordinary income just as easily as not. What I am really trying to say is that if you have an issue of stock that can produce a loss of \$1,000, it might be wise for you to sell that stock, produce a paper loss of \$1,000 and take it off your taxes for that year. If you had a real good business profit that year, this, of course, is more desirable than ever. Now if you like this particular company and think it has a nice future, you might even want to repurchase this stock after 31 days. Don't forget—you must wait 31 days before re-purchasing the same stock when you sell at a loss.

This will tend to equalize your income, which is always desirable. As you all may have probably observed, if you make \$10,000 one year and \$20,000 another year, you pay considerably more than just twice the amount of tax; whereas, if you make \$15,000 each year, your total tax bill for the two years would have been less than it was in the former comparison. So if you possibly can, each year when you have had a good profit, try to sell a stock that will produce a \$1,000 loss.

Concerning gain sales: why would anyone want to sell for gain? Well, there are a number of reasons. First of all, if you have been ill or disabled for any reason during the current year and your income is down, again, the ideal way of computing and juggling income is to create an equal income, if possible. Therefore, it would be wise, if you have stocks that have appreciated in value, to sell some of them and produce an income that will bring your otherwise reduced income up to a normal level. Now, this does another thing. If you want to repurchase the same stock, you may do so immediately. When you sell for a gain, there is no 31-day waiting period. This will increase the cost basis of the stock that you have repurchased. In subsequent years when you may sell this stock at a profit, first of all, you have less profit to report since you have already picked up the paper profit in that low income year; second, if this stock subsequently goes down, you then have a loss on the sale of the stock which may be used to offset ordinary income. So you have effectively juggled your income and created an equal or a level income situation.

Continued

TAX SHAVINGS

Continued

This is only one of the reasons for selling at gains and losses. Sometimes retirement figures in—especially is this true on the loss sales. If you expect to retire in a few years, you would be most interested in reducing your current income in any way possible; even if you had to report a gain later and you were in a retired status, it would be taxed at a much lower rate.

Mutual Fund Management Service

I know that you are all approached by a number of salesmen in the mutual funds field and I would like to say this about mutual funds, they have their place. Many times the loading rate in a particular mutual fund will exceed the brokerage rate that you would pay if you went to a firm like Merrill Lynch, Pierce, Fenner & Smith and purchased the stocks yourself. However, you must never forget that when you go to sell this stock you also have to pay a commission. This mutual fund provides a management service for your money and these people make a fulltime job of studying the market and the conditions of the companies involved, and endeavor to invest in the most wise ways. Another factor is that when you invest in a mutual company, you can forget about your investment worries, providing you have selected a mutual fund that has a reasonably intelligent investment counsel and will expend the proper amount of energy to develop the right investment ratios and investment programs.

Short-Term Trust

You may have heard something about a Short-Term Trust or a "Clifford" type, which are virtually the same. What this really means is that you must put away so much money and name a trustee to handle this money and you must do without it for no less than 10 years and one day. It can be set up on a longer period, but it can be no less than 10 years and one day. The purpose in doing this is to avoid paying your own high tax rates on the income from this money during your productive years when you are paying peak tax rates.

Consider an example of \$15,000 yielding a 4% return, which would produce \$600 in annual income. If you have four children, you can multiply this principal of \$15,000 by four and arrive at a \$60,000 investment, which can produce \$2,400 of non-taxable income by virtue of

the fact that it is taxed to the children, but they get a \$600 exemption of their own if they are under the age of 19, or even if they are over 19 and enrolled in full-time college courses consisting of 5 months or more of the calendar year. And, of course, in addition to their getting their own \$600 exemption, you get a \$600 exemption also. So if you are a 50% tax payer and you have \$2,400 coming in dividends, we'll say, this is going to cost you \$1,200 per year, plus or minus a few dollars for the dividend exclusion. However, if you place those stocks in trust for your children, you may name a bank as the trustee or you may even want to name yourself as trustee and buy and sell at will as long as you don't touch the money; however, there is some controversy on this score and to avoid any possible trouble in the future, you might be wise to name a bank as the trustee. They probably will check with you before they do any buying or selling of the stocks anyway. So, as you can see, there is a possibility of saving around \$1,200 per year if you fit the situation I just mentioned.

Establishing Testamentary Trust

A Testamentary Trust is nothing more than stating in your will that you want a certain amount of money set aside for your children. This has a number of advantages. For example, you have probably heard something about the marital deduction. When you die, your estate will probably receive some portion, if not all, of this marital deduction, which amounts to a maximum of \$60,000. This means that your estate could amount to \$120,000 conceivably and no estate tax would be paid. But, supposing that after you have been dead for two or three years, your wife meets with her demise; now we have an estate which is comprised chiefly of what your estate was after your death, only now it is in your wife's name and she is not entitled to a marital deduction. As you will see in my illustration, the tax on your estate at your death is approximately \$1,600, but when your wife dies without the marital deduction, the tax on her estate is going to be around \$20,000.

How can this be avoided? If in your will you stipulate that a certain portion or percentage of your net estate be set up in a trust for the children, it will answer many problems. First of all, when your wife dies her estate will be roughly one-half, or your total estate minus what you stipulated to be set up in the trust and,

of course, by being considerably smaller, the taxes are considerably smaller.

There are other things that can and have happened in this case. It is possible for your wife to re-marry—then die and leave the money to her new husband, and the new husband in turn gives the money to his children or relatives, and your children are completely left out. This obviously doesn't happen very often, but there are other things mentioned whereby your wife might be the victim of an investment swindle or she may be a poor manager and spend this money rapidly, and when it comes time for your children to get their education, there are no funds available for this purpose. This is all, of course, in addition to the tax savings.

You probably should and would want to make your wife a life income beneficiary of this trust you set up for the children. This gives her not only the principal portion you left her, but also the income from the children's trust. In addition to this, it is possible for you to stipulate in the trust agreement that your wife be given infringement rights. This means that in case of emergency she may invade the principal of the trust for the children to an extent stipulated by you. Sometimes this is set at \$2,000 per year on a non-cumulative basis. It is important that this be on a non-cumulative basis because this would mean that if it were not and she were entitled to withdraw \$2,000 a year and did not for a period of 10 years, it would imply that she could draw out \$20,000. If something were to happen to your wife at this point and she were entitled to receive \$20,000 from this trust, it would probably be included in her estate and we would have defeated our purpose. So it is important that there be a clause that infringement rights be limited to a certain number of dollars on a non-cumulative basis.

Investigate Well Real Estate Trusts

You have probably heard something about the new real estate investment trust. This is a relatively new type of organization that is being permitted, and I am not fully up-to-date on the ramifications of it. But I understand that it operates like a mutual fund and the only advice I can give you on this score right now is that first of all, I understand it takes 100 or more investors to form one of these organizations and as to your approach on this, I would suggest that you scrutinize the fellow investors closely

before jumping in. It would be altogether possible for a group of real estate sharpies to unload a lot of junk property and have it appraised at high and unrealistic values, and if you invested your money in such a real estate investment trust, it might immediately be worth only half of what you invested. This is a possibility, so investigate thoroughly before you invest.

Now there is another type of association or organization which has been the subject of much talk recently and that is the much publicized Kintner type association and/or more nearly like the type the Treasury Department explains, and that is the Galt type. Some of you have read about this bill and know that it did not pass the house in this last session. I called Mr. Elmer Lyons, the author of the bill, and he brought me up-to-date on it. He seems to think that it failed because of its newness and that by the time two more years have passed, the bill will be more thoroughly understood and probably accepted as a good thing. It is true that it has certain corporate features that are desirable, or seemingly so, such as the fringe benefits of insurance, expense allowances, etc.; however, I would like to point out that currently these so-called fringe benefits, which accrue to corporate executives, are being scrutinized very carefully and are in danger of being limited—if not eliminated. So I would suggest that if and when the bill does pass in Indiana, you look into this very carefully before you attempt to form such an association.

Depreciation

Here is an item of tax savings which is held out more or less like a plum in front of you and I think, in fact, hoping that you will grab for it. There is what is known as a first year's special depreciation clause. This was allowed in part of the 1958 Technical Amendments Act. This provision permits your taking a larger amount of depreciation the first year of acquiring depreciable personal property (this does not include real estate or buildings) with an estimated life of six years or more and totaling not more than \$10,000 for the taxpayer; and if he files a joint return, this total can be up to \$20,000.

You can take 20% of the total cost, up to the limitations that I mentioned, as a depreciation deduction in the first year. What I want to point out to you is that this, in my estimation, is very undesirable in some cases. If you were a young man starting your general practice, you

TAX SHAVINGS

Continued

probably would not exceed the 20% or 22% tax rate the first or second year of operation. After you had been in practice three, four, or five years, your tax rate probably would go up to 34, 38, 43, or 47%. In other words, the same dollar that would save you 20% or 22% if you took it the first year when you bought all of your equipment, would now save you \$38 or \$43 on the hundred; so to me it doesn't seem advisable to reach out and grab this deduction the first year you are in business when you could wait and make money on it.

The same rule, as far as I am concerned, applies to fast write-off methods of depreciation. They have their place, but I don't think their place is on routine business equipment like your examining tables, treatment stands, desks, typewriters, files, etc., because the same situation exists here. When your income is the lowest you are entitled to take the largest depreciation deduction. This doesn't make sense to me, because later on when your tax rates are higher, you have no depreciation deductions left, so the winner in this situation as far as I am concerned is Uncle Sam. He did not do you a favor by permitting you to take this deduction.

Leasing Cars

There is one question asked me almost every week. A client will ask, "Gene, should I lease a car or should I continue to buy one?" This is quite problematical because there are many questions involved. First of all, it depends upon how many miles you put on an automobile in a year. Second, it depends upon whether automobiles are a sort of a hobby with you. I have come to the conclusion that as a rule of thumb that probably if you drive 20,000 miles or more during the year and are satisfied to drive an economy model automobile, it is advantageous for you to lease a car rather than buy one. However, if you want to drive a more expensive automobile, the same theory on investment holds true on cars—the larger the investment, the larger the profit the company is going to make, so I would suggest that if you are going to drive an expensive automobile, you would probably be wise to buy it and own it yourself.

Contract Sales

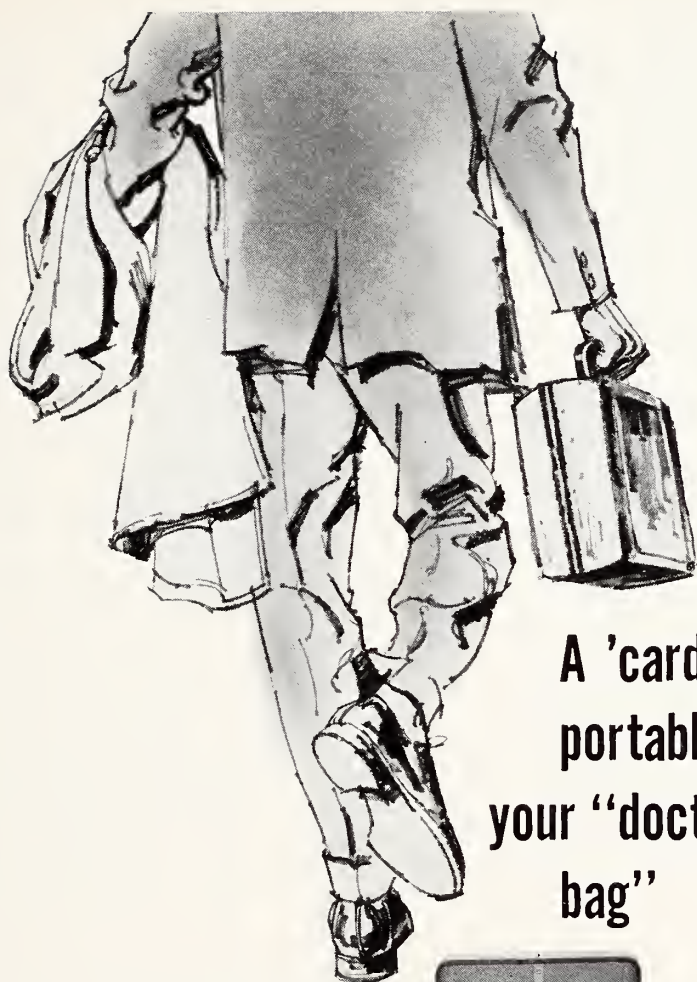
A subject which you may or may not come in contact with, but sooner or later you probably

will, is contract sales of property, the tax results of which may be juggled according to the terms at the time of the sale. Sometimes if you wait a year or so, it's too late to take advantage of all the tax savings there are available. If the total payment on a contract (the total payment includes receipts during the first year) is less than 30% of your selling price, the gains may be reported on an installment basis, which means that as you receive the payments, a certain portion of it is profit and can, of course, be long-term capital gains and reported as such as received. This decision, however, must be made during the year of sale. You cannot go back and file an amended return and change it to an installment method of reporting the profit. If the payments during the first year of the sale exceed 30%, you must report the entire gain in the year of sale. And, of course, these, too, may be long-term capital gains. So I would advise you to consult your attorney and your accountant before completing or signing a Conditional Sales Contract or any contract, for that matter as well as any of the tax-saving methods employed herein.

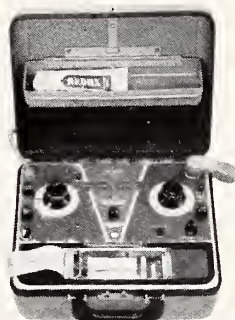
Contributions as Tax Savings

There is another little item I would like to mention—contributions. Handled properly, contributions can effect a nice tax savings. If you are only a moderate philanthropist and each year it seems as if your Page 2 Deductions listing your contributions, taxes, and interest, miscellaneous deductions, casualty losses, etc., just come right to the \$1,000 mark but never seem to go over, I would suggest that you consider alternating years of contributions. You have fixed deductions, such as real estate taxes, personal property taxes, etc., that cannot be avoided, and if those total around \$400 to \$500 per year and your contributions run about \$500 a year, what you can do is to make no contributions one year. That gives you an actual Page 2 total of around \$400 to \$500 and the government will allow you up to 10% or no more than \$1,000 without any argument. So you take the \$1,000 that year and save the taxes on the \$400 to \$600 differential. Then the following year you contribute two years' pledges in one. This gives you an itemized Page 2 of about \$1,500. Then, of course, that year you have exceeded the standard deduction by \$500 and have saved the tax on that. This is just a little thing you might consider doing.

Continued



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TAX SHAVINGS

Continued

In conjunction with contributions there is always the possibility of giving away appreciated property rather than cash. If you have some stocks that were purchased at a price that is now higher, you may circumvent the tax on this gain by giving the stocks directly to the charitable organization. They may then sell the stock and are not subject to the tax; whereas if you sold it and realized a profit, you would have to pay a tax on the gain and then give the money to the church or charity organization—which ever the case may be. Of course, if you have stocks that are down, you certainly would not want to give those to a charitable or religious organization—you would want to sell those in order to pick up the short term loss.

One taxpayer made money by contributing. He bought a city block in a small town, paid \$3,000 for it. He was going to give it to the city immediately as a park and I suggested to him that he hold on to it and since it had a slight ravine in it, I thought perhaps we could have some fill dirt hauled in the next time someone dug a basement or built a highway or something of that nature and level it off, which we

did. Three years later, in fact December 30, 1960 we had it appraised. Three residents of this city signed affidavits as business men appraising land at \$5,750 as business property. Now, this man happened to be in the 69% tax bracket. The tax savings on the \$5,750 contribution was \$3,967. He only paid \$3,000 for it in the first place, so he made \$967 by being so generous. ◀

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W. B. SAUNDERS COMPANY features the following recent books in their full page advertisement appearing elsewhere in this issue:

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KIT USED by Dr. George F. Holland prior to World War I (top), an old-style surgeons kit, surgical kit used by P. C. Holland, and an early medical kit used by P. C. Holland and, at the bottom, a medical kit from the 1930's.



Mainstay of American Medicine

Our Journal and cover this month are dedicated to the General Practitioner — mainstay of today's medicine as he was in times gone by.

Photographs used on the cover and this page, reminiscent of the well-recognized images of "horse and buggy" physicians, were taken by Dr. Philip T. Holland, Bloomington. Bags and equipment were used by Dr. Holland's maternal grandfather, L. L. Todd (M.D., 1858), by his older brother R. N. Todd, M.D., both of whom practiced in Indianapolis, and by Dr. Holland's paternal grandfather, Philip C. Holland (M.D., 1869), and his son, George Frank Holland, (M.D., 1903), both of whom practiced in Bloomington. Dr. Holland is the son of Dr. George Frank Holland.

These were early practitioners who made their calls on horseback and by horse and buggy. Dr. George Frank Holland bought his first automobile in 1908 or 1909.

The Journal is indebted to Dr. Holland for making this material available to us for the General Practitioners' issue. It is indeed commemorative of the best traditions of the medical profession. ◀

Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.

Indianapolis

Although various studies have been done over the last sixty years on the same subject, a recent paper by Lankowsky¹ is of interest because of his prolonged follow-up. The problem was to see if there was a significant and prolonged higher hemoglobin level produced in infants after delayed clamping of the umbilical cord with "milking" of blood from the cord into the neonate, as contrasted with immediate clamping. The cords of 63 infants were clamped immediately, while 70 were clamped after signs of placental separation and four or five stripping maneuvers. All deliveries were normal and uncomplicated. The mean hemoglobin levels in the delayed clamping group were significantly higher in the periods of 13 to 24 hours and 72 to 96 hours than the levels in the early clamped group. This difference had disappeared on repeated levels at three months of age. The authors concluded that the advantages of late-clamping and stripping would be of importance only in premature infants or in those infants born after traumatic deliveries.

Different Types of Hyperglycemia

Four cases of hyperglycemia following burns are presented by Bailey² to show the different types of hyperglycemia that can occur. The three causes are (a) activation of a prediabetic state; (b) adrenal medullary hyperfunction and (c) adrenal cortical hyperfunction. The medullary overactivity, he reports, is a transient condition that comes on soon after the burn, and lasts only about 48 hours. This is thought to be a pure stress phenomenon. However, the adrenal cortical hyperfunction is likely to come on several days after the burn and be more severe. It was more marked, but was not accompanied by ketosis, and was resistant to insulin. With past reports of psychiatric symptoms that have been

noted in Cushing's syndrome, it is interesting that the patients in the current report who showed the adrenal cortical hyperfunction also had severe psychiatric upsets.

Megaloblastic Madness

Attention to the occurrence of psychiatric symptoms as a manifestation of another medical disease is given by Smith³ in the paper "Megaloblastic Madness." Six cases are presented to again stress the association of mental symptoms with pernicious anemia. These symptoms, and an abnormal EEG may be the only positive finding, so that this condition can precede the peripheral neuropathy that might be expected. The author states that much larger doses of B12 are needed for successful treatment of this complication. One of the patients had the mental symptoms and macrocytic anemia following gastrectomy.

Reiter's Syndrome with Aortic Insufficiency

Csonka et al.⁴ describe three patients (and possibly a fourth) with Reiter's syndrome and aortic insufficiency. Although the triad which composes Reiter's syndrome—arthritis, conjunctivitis, and urethritis—is not rare, there had been no previous instances of this cardiac lesion with the syndrome. Csonka has seen about as many patients with Reiter's (215) as anyone alive. Carditis, with a prolonged P-R interval has been known to be associated with Reiter's for some time. The author reports that 3 of the 4 patients had iritis, whereas the usual incidence of this complication is only 17%. This can lead to speculation as to whether Reiter's may in fact be a hypersensitivity condition comparable to the reaction of the body to streptococcal infections by rheumatic fever or glomerulonephritis, as has been suggested in the past. With the high hyaluronic acid concentration in the eye, and other affected parts

of the body, Reiter's syndrome could end up as a sort of collagen disease, only with its own substrate that is affected. These thoughts are no more than speculation at this time, and further observations are necessary.

Refers to Dr. Travell

With the new appointment of Dr. Janet Travell as JFK's personal physician, some note must be given to a report by Ellis,⁵ in which he pays frequent reference to previous works by Dr. Travell. The author describes use of ethyl chloride spray in the treatment of a number of conditions, for the relief of pain. Although the number of treated patients is not given, Ellis states that he has had good results in treatment of lumbago, acute wryneck, fibrositis, renal colic, dysmenorrhea and fractured rib. The author says that a longer nozzle with a larger diameter is needed than the one that is on the usual ethyl chloride bottles. He cautions against actual freezing of the tissue. Repeated treatments were needed in some of the patients, but often the duration of relief was far longer than could be accounted for by the actual analgesia produced by the ethyl chloride.

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1. Lanzkowsky, P.: Effects of Early and Late Clamping of Umbilical Cord on Infant's Haemoglobin Level. *Brit. Med. J.* 5215: p. 1777, 1960.
2. Bailey, B. N.: Hyperglycemia in Burns. *Brit. Med. J.* 5215: p. 1783, 1960.
3. Smith, A. D. M.: Megaloblastic Madness. *Brit. Med. J.* 5216: p. 1840, 1960.
4. Csonka, G. W. et al.: Cardiac Lesions in Reiter's Disease. *Brit. Med. J.* 5221: p. 243, 1961.
5. Ellis, M.: The Relief of Pain by Cooling of the Skin. *Brit. Med. J.* 5221: p. 250, 1961. ◀

In a small town, the sheriff was also the vet. Late one night he received a frantic phone call.

"Do you want me as sheriff or vet?" he asked.

"Both," came the reply, "we can't get our dog's mouth open . . . and there's a burglar in it."—Quote, Vol. 41, No. 9, 1961.

A policeman saw a woman lying in the gutter on Main Street. Frontally he asked her, "Are you hurt badly, Madam?"

"Oh, no, I'm not hurt at all," replied the woman. "I'm just saving a parking space for my husband."—Quote, Vol. 41, No. 12, 1961.

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August 1961 1201

ABSTRACTS

BOOK REVIEWS

STROKE

Douglas Ritchie, Editor; Price \$3.50; pp. 192; Doubleday & Company Inc., February, 1961.

A poignant story in the first person, by a victim of a major stroke . . . a story of determination, unstinting fortitude and unlimited patience on the part of his wife.

This volume should be a constant stimulus both to families and physicians in caring for patients with strokes.

The slow recovery to a semblance of normalcy should give encouragement to those who would despair at the lack of speed in recovery.

It is indeed a monument to man's limitless will to recover.

Walter L. Portteus, M.D.
Franklin

DISEASES OF THE SKIN

James Marshall, M.D., The Williams and Wilkins Co., Baltimore 2, Md., exclusive U.S. agents.

This book consists of 944 pages and 496 excellent black and white illustrations. It is considered well worth reading for anyone with an interest in dermatology. The subject matter is presented in an orderly, satisfactory arrangement and the nomenclature used is standard. The book is written in a concise, straight to the point manner and the language is clear and often picturesque. The text is interesting and is easily understood. A small bibliography is attached; however, the book is essentially a recounting of the experiences and opinions of a learned and able dermatologist. The author is from South Africa and diseases more common to that area are covered more thoroughly than in many books by American authors. This book covers all of the common dermatological conditions and most of the rarer ones, although it would not qualify as a reference edition. Some sections, particularly those dealing with the pathological physiology of the various dermatoses fall short of comparable books by American authors.

Stephen R. Phelps, M.D.
South Bend

SIGHT: A HANDBOOK FOR LAYMEN

Roy O. Scholz, M.D., Doubleday & Company, Inc., 1960. 162 pp., 13 figures, \$3.50.

This book admirably fulfills the author's desire to offer laymen a clear and informative résumé of problems related to the eyes. The need for such a text is well acknowledged, and Dr. Scholz's lucid and unstilted style should allow this book extensive use by ophthalmologists everywhere.

Division of chapters and well-outlined table of contents facilitate finding the discussion of a particular topic. Chapters themselves cover the salient features of a particular problem with a minimum of extraneous material and words. The addition of a historical background, where applicable, is interesting and well received. Also, limited use of statistics enhances the points to be emphasized. Too often, an important point loses its impact under a barrage of unnecessary figures and percents.

Sections dealing with glasses and the refractive errors are especially informative. The chapter devoted to astigmatism is quite good, but is not completely clear. Many patients regard this type of ametropia as a serious handicap which precludes them from normal vision. Although the point was well stressed that astigmatism is a common finding but seldom difficult to correct, perhaps an example or analogy might further allay their fears. An analogy, which I find useful, is to regard the cornea in simple myopia or hyperopia smooth as a ping-pong ball, and the astigmatic cornea as the bowl of a spoon which has obviously unequal curvatures.

The role of the specialist in the field of contact lenses seemed slighted. A large volume of advertising infers that these lenses are harmless and can be easily worn by anyone. Safe and successful wearing is achieved through the efforts of a skilled and competent specialist or under his direct supervision.

Sections pertaining to children's eyes, strabismus, glaucoma and cataracts are very well covered, and should enjoy a wide appeal. The other chapters, which have a more limited appeal, maintain the high caliber set by Dr. Scholz in his first chapter.

This book is recommended as a valuable addition to the library of every conscientious oculist. All too frequently the busy practitioner has but a few moments for more than a cursory explanation of his patient's malady. This excellent handbook bridges this gap, and is a definite and very worthwhile contribution to ophthalmologists and their patients.

Michael H. Lashmet, M.D., Resident
Indiana University Medical Center

COMPARATIVE MEDICINE IN TRANSITION

Proceedings of the first institute of Veterinary Public Health Practice, Oct. 6-9, 1958, University of Michigan School of Public Health, Ann Arbor, Michigan.

Compiled by a Board of Editors, Henrik J. Stafseth, D.V.M., Ph.D., Chairman, and written by over 60 contributors. Pub. by U. of Mich. School of Public Health; Lord Baltimore Press, Inc.; 494 pp.

This book is a grouping of ideas by a number of individuals who are interested in various phases and aspects of medicine. They have expressed their views on the role of the veterinarian in various medical fields.

The authors point out the qualifications of veterinarians for public health and related medical fields. They have shown how the field of veterinary education has paralleled the human field in raising educational re-

Continued

CONTROL OF STAPH EPIDEMIC IN SMALL NURSERY

Zupanc, E.: Control of Staph Epidemic in Small Nursery. *Am. J. Dis. Child.* 101:434, April, 1961.

The purpose of this report was to reveal the problems encountered when a staphylococcal epidemic occurred in a small newborn nursery, and to discuss the measures adopted to control it and prevent a recurrence. In one month, 16 of 62 newborns were found to have staphylococcal infection which was contracted in the nursery. After therapeutic and prophylactic administration of erythromycin, all nursery procedures and techniques were reviewed, and many changes were made. In addition, a staphylococcal-infection control program was initiated and rigidly followed. In the seven months following the staphylococcal control program, only three newborns were found with evidence of staphylococcal infection. These were discovered because of the effectiveness of the program, thus avoiding another outbreak.

TRACHEOSTOMY IN THE MANAGEMENT OF RESPIRATORY PROBLEMS

Head, J. M.: Tracheostomy in the Management of Respiratory Problems. *New Eng. J. Med.* 264:587, March 23, 1961.

A series of 462 cases was reviewed in an effort to clarify indications for the use of tracheostomy and to determine complications following the procedure. Better understanding of respiratory physiology and tracheo-bronchial toilet has led to more frequent tracheostomies.

The major hazards are infection, cannula occlusion, and tracheal bleeding; they can be partly avoided by using proper cannulas and after-care techniques. Mechanical respiratory assistance increases the hazards because a cuffed cannula is required. The benefits of tracheostomy outweigh the hazards.

TREATMENT OF ACUTE RHEUMATIC FEVER

Dorfman, A., Cross, J. I., Lorincz, A. E.: Treatment of Acute Rheumatic Fever. *Pediatrics* 27:692, May, 1961.

A controlled study of therapy was conducted on 131 patients with first attacks of acute rheumatic fever of 18 days or less duration. All patients were maintained on a basic regimen of bed rest and initial penicillin therapy followed by sulfadiazine prophylaxis. The effect of the basic regimen was compared with those of hydrocortisone, salicylates, and a combination of these two agents. Both acetylsalicylic acid (Aspirin) and hydrocortisone favorably affected certain acute manifestations, the effect of the latter was more striking. Treatment with hydrocortisone appeared to result in a decrease in apical systolic murmurs by the end of one year as compared with acetylsalicylic acid or no specific antirheumatic therapy. No advantage of combined therapy was found. It is recommended that acute rheumatic fever with carditis should be treated with hormones, but, in the absence of carditis, salicylates should be employed. ◀

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Economics of Medical Care

(One of a series presented by Blue Cross—Blue Shield)

Extracts from a speech by Harry Hineman, Director of Blue Cross-Blue Shield Actuarial Division, made at the 1961 Indiana Blue Shield Seminar for the Advisory Council.

The medical scientist has shaped economics of health care just as much as he has controlled disease. Every new discovery saves or prolongs life, but the economic effect is always a net increase in the cost of health care.

The economics of health care is closely tied to the practice of medicine. Let's take a look at some facts and figures to see how Blue Shield and Blue Cross have supported you in your work. In the last 10 years, Blue Shield payments to doctors have risen from \$2,418,000 in 1950 to \$15,752,000 in 1960 for a total paid to doctors since 1946 of \$103,564,000. Blue Cross cases have risen from 64,585 to 191,301, and payments from \$6,080,000 to \$43,634,000 for a total, since 1944, of \$274,711,000.

Blue Shield claims per 1,000 participants per year since 1953 have increased from 152.5 to 346.7.

In the same period Blue Cross claims per 1,000 persons per year have increased from 114.5 to 130.3.

Blue Cross in-patient cost per day has increased from \$18.70 to \$28.02.

Blue Cross days per hospital case have increased from 7.12 to 7.95.

I think you can see where these figures are going next year and the year after that and on and on. They don't choose a direction all their own. They are moving in this manner because we all help point the way. I firmly believe that, if the voluntary health care system has one "Achilles heel" it is the upward spiral in costs which we are all experiencing and which many of us are promoting.

Just who is involved in the development of a health care plan? First are the consumers—your patients. Second—the providers of service . . . doctors, hospitals and other health agencies. Third—the mass purchaser of these services (either a Union or a Company), and, fourth—the insuring organization. Every enterprise which has ever been organized has been designed

with one major principle in mind: to yield relative advantage to one person or group of persons and of course, relative disadvantage of all others.

Let's give a priority for advantage in the establishment of our imaginary health care plan. This priority will determine the form our health care plan will take. If our first priority is to doctors and hospitals, it will take one form; if it is the people, the plan will have another form; if it is the mass purchaser or insuring organization, it will take still another.

To speed things up, let's assume the priority to advantage is in this order:

1. People
2. Doctors and hospitals
3. Mass purchasers
4. The insuring organization

To give people the advantage, our plan must provide broadest possible benefits, at lowest possible cost, and pay the maximum amount toward total costs. This means non-profit operation, service benefits and complete range of services. Next, for the providers of services our plan should assume payment for every service rendered, maximum enrollment, and should assure to the maximum possible that funds paid in are used to purchase health care benefits.

If we reverse the order of priority, we have a completely different health care plan—one that is based on profit to the insuring organization rather than service to the people.

How do all these items we've discussed fit together? What's the relation between Blue Shield costs, Blue Cross costs, prepayment plans, government plans and finally, insurance companies. Each of these are elements or institutions in the economics of health care. Regardless of your wishes and my wishes, each of these will exert considerable influence in shaping the practice of medicine. I believe all of us want better and better medical care for our people, provided at the lowest possible cost. If you think as I do that our present system will best achieve this end, we should take action now to strengthen it. Of course, we in Blue Shield and Blue Cross can assist in this task, but the ultimate decision is yours. ◀

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nervous patient



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- 4 does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- 5 does not muddle the mind or affect normal behavior

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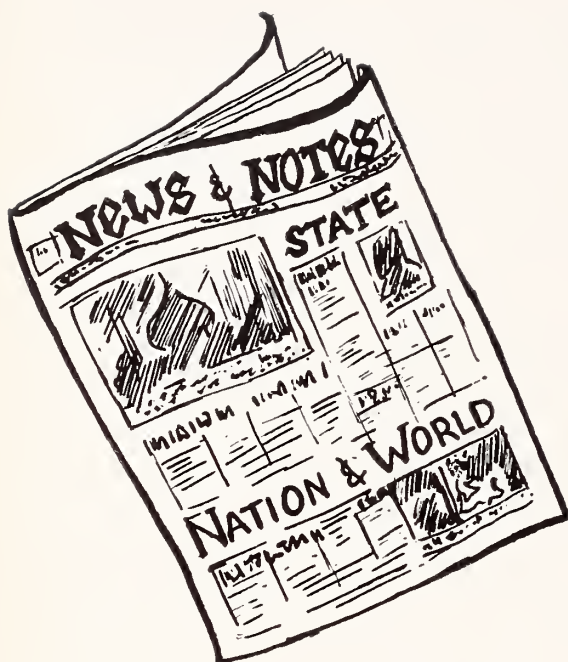
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CM-4730



One Project Approved in April, Four in May Under Hoosier Hill-Burton Grants

The Department of Health, Education and Welfare has reported that as of April 30, Indiana Hill-Burton Grant status included one project approved, for Oaklawn Psychiatric Center, Elkhart, at an estimated cost of \$753,850, including a \$232,200 federal share.

Also at that time, 68 projects were completed in operation, at a \$72,869,255 total cost, and including a federal contribution of \$23,828,304. They will supply 3,172 additional beds.

Thirty-one projects were under construction. These, designed to supply 1,346 additional beds, will cost \$39,059,560, with a \$10,349,818 federal share.

Also as of April 30, two projects, costing \$1,873,650, including a \$582,200 federal share and supplying 51 additional beds, were approved but not yet under construction.

The Department reported that during May the following projects were approved: DeKalb

Memorial Hospital, Auburn, \$1,922,000 estimated cost, with \$610,000 federal share; Parkview Memorial, Fort Wayne, \$120,000 estimated cost, with \$40,000 federal share; Henry County Hospital, New Castle, \$1,350,050 estimated cost, with \$400,000 federal share, and Pulaski Memorial Hospital, Winamac, \$850,288 estimated cost with a \$270,000 federal share.

The May 31 report also lists 66 projects completed and in operation. These, supplying 3,817 additional beds, cost \$80,266,763, and included a \$26,445,339 federal contribution.

Under construction at that time were eight projects, costing \$18,053,366, including a \$4,729,749 federal contribution and supplying 738 additional beds.

Approved but not yet under construction were four projects, costing \$5,242,138, with a \$1,630,000 federal contribution, and supplying 214 additional beds.

I.U. Student Elected SAMA Officer

Rudy Kachmann of Indiana University School of Medicine was elected as vice-president of the Student American Medical Association for Region 4 at the recent annual meeting of the association. Region 4 includes the states of Michigan, Ohio, Kentucky, Missouri, the southern half of Illinois and the eastern two-thirds of Tennessee.

NEW GLAUCOMA PAMPHLET FOR DISTRIBUTION TO PATIENTS

"Living with Glaucoma" is an attractive pamphlet published by the National Medical Foundation for Eye Care and intended to be distributed to patients. It sets out in text and illustration a list of rules or principles for the glaucoma patient. It is the hope of the Foundation that every glaucoma sufferer in the United States will have a pamphlet. They are sold by the Foundation at five cents each or \$3.00 per hundred. The address is 250 W. 57th St., New York, 19.

New Pharmaceutical Firm Introduced in June

A new pharmaceutical manufacturing firm, Philips Roxane, was introduced in June and

sponsored an exhibit at the AMA meeting in New York. The company was formed under the sponsorship of several corporations with worldwide interests. Philips Electronics and Pharmaceutical Industries Corp. and N. V. Philips-Duphar, both of the Netherlands, and the Columbus Pharmacal Company of Columbus, Ohio, were principally concerned. Columbus Pharmacal will form the marketing organization for the new combination and will operate in the future under the Philips Roxane name.

Vaccinia Immune Globulin Now Available from American Red Cross

Vaccinia Immune Globulin (VIG) may now be obtained, for use where indicated, from the American Red Cross. VIG is gamma globulin prepared from blood of persons recently vaccinated against smallpox. It contains a high titer of antibodies and may be used to counteract abnormal reactions to vaccinia virus. It may be used to produce a boost in immunity in a patient recently exposed to smallpox, and is of greatest help in cases suffering with a complication of vaccination.

Accidental inoculation of the eye with vaccinia virus, widespread vaccinia reaction in pre-

Continued

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NEWS NOTES

Continued

existing eczema (eczema vaccinatum), generalized vaccinia or vaccinia necrosum are all conditions where VIG is lifesaving. It is not suitable for such lesions as chicken-pox, or herpes zoster, for normal vaccinations with febrile reaction, pain and swelling of a normal "take," or for trivial secondary inoculations on non-vital areas of the body. It may be obtained by calling the nearest Red Cross regional blood center.

Dr. Burney Accepts Post As Vice President at Temple U.

Dr. LeRoy Burney, formerly Secretary of the Indiana State Board of Health, and most recently Surgeon General of the U.S. Public Health Service, has been appointed Vice President for the Health Sciences at Temple University. The position is a new one and carries administrative responsibility for all educational activities related to the health sciences, the Temple University Hospital and its affiliated hospital relationships.

Educational activities under Dr. Burney's office will include the schools of dentistry, medicine, medical technology, nursing, oral hygiene, pharmacy and any graduate activities in these areas.

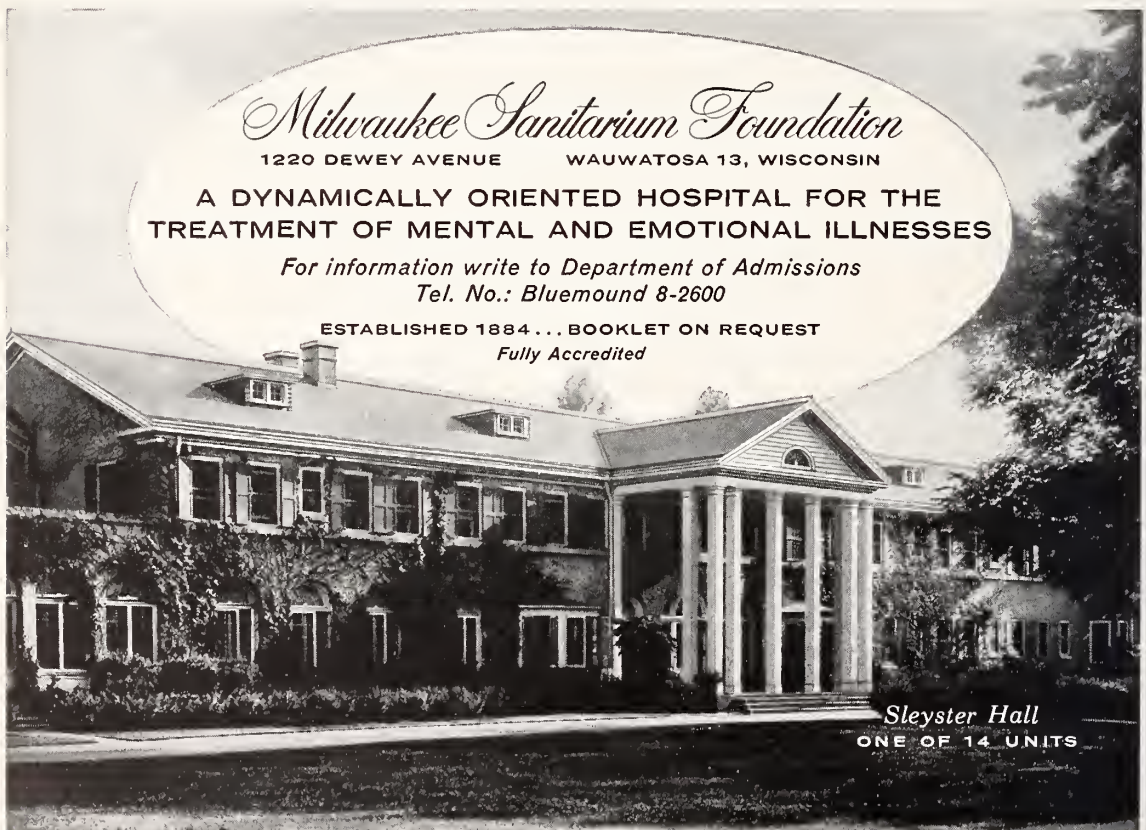
INDIANAPOLIS STUDENT HONORED

Lawrence Reitz of Indianapolis has received the 1961 Pitman-Moore award as the second-year Indiana University medical student "showing the most promise in applying pharmacologic principles in medicine."

The award which consists of a plaque, and \$100.00 was presented by Dr. Lawrence Weaver, head of bio-medical research at the Pitman-Moore pharmaceutical plant in Indianapolis.

Ob-Gyn Board Part 1 Exam No Longer Requires Case Reports

The next scheduled examination, Part 1, written, of the American Board of Obstetrics and Gynecology will be held in various cities of the United States, Canada, and military centers outside the Continental United States Friday, Jan. 5, 1962.



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Case reports are no longer required by the board to complete the Part I examination.

In lieu thereof, all applicants and candidates for examination are required to submit a duplicate certified typewritten list of patients dismissed from each hospital during the preceding 12 months. This applies to new applicants, re-opened candidates and candidates requesting re-examination in Part I or Part II.

Lists of obstetrical and gynecological patients are to be made separately and must conform in all details to the sample format furnished upon request by the office of the executive secretary and treasurer.

Candidates are no longer required to bring a duplicate list of admissions to the Part II examination.

Current Bulletins may be obtained by writing to: Robert L. Faulkner, M.D., Executive Secretary and Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

Notice sent out by London Hospital studying brain damage from boxing: "Gentlemen boxers who would care to further the cause of science by leaving their brains to this department when they die, please contact us. Intending benefactors may rest assured that any contributions, however small, will be gratefully received.—Reported in *Insider's Newsletter*.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL, 1961

Surgical Technic, Two Weeks, September 18
Surgery of Colon & Rectum, One Week, September 18
Gallbladder Surgery, Three Days, October 9
Surgery of Hernia, Three Days, October 12
Basic Principles in General Surgery, Two Weeks, October 16
Surgical Board Review, Part I, Two Weeks, November 6
Surgical Board Review, Part II, Two Weeks, November 27
General Surgery, One Week, September 18
Hand Surgery, One Week, October 9
Gynecology, Office & Operative, Two Weeks, September 18
Vaginal Approach to Pelvic Surgery, One Week, September 11
Obstetrics, General & Surgical, Two Weeks, October 9
Basic Electrocardiography, One Week, October 2
Internal Medicine, Two Weeks, October 16
Fractures & Traumatic Surgery, Two Weeks, October 23
Thoracic Surgery, One Week, October 16
Blood Vessel Surgery, One Week, November 13
Urology, Two Weeks, October 23

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FUTURE MEETINGS, SEMINARS, COURSES

GASTROENTEROLOGISTS ANNOUNCE ANNUAL POSTGRAD COURSE

The American College of Gastroenterology announces its annual postgraduate course in gastroenterology to be held at the Sheraton-Cleveland Hotel in Cleveland on Oct. 26-28, 1961. Subject matter will cover both medical and surgical viewpoints and will be devoted mostly to the advances in diagnosis and treatment. Write the College at 33 W. 60th St., New York 23.

Postgraduate Association To Meet in Cleveland

The Interstate Postgraduate Medical Association of North America has scheduled its annual assembly for Nov. 13 to 16, 1961. The meeting will be in Cleveland. Doctors are urged

to make plans early in order to obtain hotel reservations. Full details may be obtained by addressing Dr. E. R. Schmidt, Box 1109, Madison 1, Wisc.

AMA Plans Congress on Quackery With Food and Drug Administration

A Congress on Medical Quackery, to be held jointly with the Federal Food and Drug Administration in Washington, D. C., Oct. 6-7, is being planned by the American Medical Association. It will be held at the Sheraton-Park Hotel.

The AMA has for many years maintained a formal program combating medical quackery as the chief function of the Department of Investigation, now part of the Legal and Socio-Economic Division. The Food and Drug Administration has also been active in the product aspect of this problem for many years, as have other federal agencies.

Continuity of Patient Care Subject to Statewide Convo

A statewide conference on continuity of patient care entitled "Round Trip Ticket for Patients—via Community Resources" will be held Wednesday, Sept. 27, 1961 in the Student Union Building, Indiana University Medical Center.

The conference is planned to stimulate improved planning for patient care and is being sponsored by the Central League for Nursing in cooperation with the Indiana State Medical Association and other state and local organizations.

The program will be helpful to physicians, nurses, social workers, administrators and all other disciplines interested in patient care.

Ohio Surgeons Extend Invitation

All Indiana physicians are invited to attend the sixth annual meeting of the Ohio Chapter of the American College of Surgeons, Sept. 22-23, at the Netherland-Hilton Hotel, Cincinnati. The program will cover 1961 surgical problems.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF "THE PROBLEM DRINKER"

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- the most modern, coordinated, comprehensive, rehabilitative regimen
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In the field of medicine, as almost everywhere else in a free economy, the trademark concept has evolved over the years. As with most human institutions, there are some who may not consider it ideal; but it has brought about three signal benefits:

To the physician it gives assurance of quality in the drugs he prescribes—assurance backed by the biggest asset of the maker, his reputation.

To the manufacturer it gives one of the greatest possible incentives to produce new and better curative agents.

To the pharmacist it gives preparations which he can dispense with confidence.

If trademarks are done away with, a whole new setup must be created:

1. An enormously expanded, expensive system of government quality control.
2. A new system of generic nomenclature which would magically turn out names not only rememberably simple, but also conforming to the principles of complex chemical terminology.
3. Something new to fill the gap left by the elimination of the trademark incentive to produce new and better drugs.

The American system has been pre-eminent in producing and distributing good medicines. Above all it has been successful in creating new advances in therapy. In a dubious effort to provide cheaper medicines by abolishing the trade names upon which the responsible makers stake their reputations, let us beware of sacrificing this success.

*This message is brought to you on behalf of the producers of prescription drugs to help you answer your patients' questions on this current medical topic. For additional information, please write **Pharmaceutical Manufacturers Association**, 1411 K Street, N. W., Washington 5, D. C.*

Deaths

Anson G. Hurley, M.D.

Dr. Anson G. Hurley, Muncie surgeon, and three members of his immediate family were killed in a crash of his private plane June 24 while en route to the AMA annual meeting in New York.

A graduate of Northwestern University Medical School in 1934, Dr. Hurley had practiced in Muncie for 20 years. He was senior surgeon at Ball Memorial Hospital, and had served as president of the Delaware-Blackford Medical Society in 1954.

Edward M. Pitkin, M.D.

Dr. Edward M. Pitkin, 68-year-old Martinsville physician, passed away June 17. He had practiced in the Morgan County town for 34 years.

A graduate of the I.U. School of Medicine in 1922, Dr. Pitkin received the Ravoin Medal upon graduation for attaining the highest scholastic average in his class. He was assistant professor of anatomy before becoming medical

director at the Martinsville sanitarium in 1925. In 1933, he began private practice.

Dr. Pitkin was past president of the Morgan County Medical Society.

James C. Rhea, M.D.

Dr. James C. Rhea, 63, who practiced medicine at Beech Grove for 37 years, passed away suddenly June 4.

A graduate of I. U., Dr. Rhea was on the staff of St. Francis, Community and Methodist hospitals in Indianapolis. He was a World War I veteran, and was active in the Beech Grove post of American Legion.

S. A. Smoots, M.D.

Dr. Samuel A. Smoots, 81-year-old Terre Haute and Corydon physician, and a member of the ISMA 50-Year-Club, passed away June 14. He had practiced in Vigo County since graduation from the University of Louisville School of Medicine.

A World War I veteran, Dr. Smoots was a former Harrison County schoolteacher. He had been active in the Masonic lodge and American Legion. ◀



Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy.. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.



District, County News

Second District

Senator Homer Capehart spoke to members of the Second District Medical Society at that group's annual meeting in Washington, Ind., June 15. Members of the Daviess-Martin Medical Society acted as hosts for the evening, which included a dinner prior to the Senator's talk.

Eighth District

Seventy-eight members of the Eighth District Medical Society and their wives attended the annual meeting of that group, June 14, at the Delaware Country Club. Bridge for the wives and golf for the doctors preceded a business meeting at which Dr. Guy Owsley, ISMA President, addressed the group.

Newly-elected district officers are Drs. Leroy B. Chambers, president; C. Rudolph Chambers, secretary-treasurer and Fletcher McDowell, Blue Shield representative.

Adams

Three recent meetings of the Adams County Medical Society included special scientific programs. On March 14 the group heard Dr. Richard C. Haller, Fort Wayne, discuss epilepsy. At their April 12 meeting, Dr. James Chase, industrial physician from the General Electric Plant, discussed that company's insurance program. At a May 9 meeting, 13 members viewed a film on tranquilizers.

Dearborn-Ohio

Dr. George Morrison is the newly-elected president of the Dearborn-Ohio Medical Society. Assisting him are Drs. Henry Conrad, vice president; F. A. Streck, secretary-treasurer; Gordon S. Fessler and Lowell G. Hunter, delegates; and Dr. Streck and John K. Jackson, alternate delegates.

Dubois

Dr. John M. Paris spoke on "Impending Social Security Legislation" at the June 8 meeting of the Dubois County Medical Society at Huntingburg. Fifteen members attended.

Montgomery

Dr. John I. Nurnberger, I. U. School of Medicine, spoke on "The Psychological Reason for the Remarkable Effect of Placebos and Doctor-

Patient Relationship" at the June 15 meeting of the Montgomery County Medical Society at Crawfordsville. Twenty-eight members were present.

Rush

Dr. Harry G. McKee is the newly-elected president of the Rush County Medical Society. Other officers for 1961 include Drs. Stephen Smith, vice president; Charles E. Sheets, secretary-treasurer; and Frank Green, delegate.

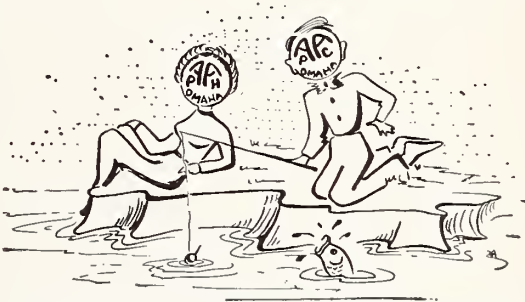
Pike

Members of the Pike County Medical Society serving as officers for 1961 are Drs. Milton Omstead, president, secretary and delegate, and Donald Hall, vice president and alternate.

St. Joseph

Dr. James M. Wilson took office June 1 as president of the St. Joseph County Medical Society. Other new officers are Drs. Sherman L. Egan, president-elect; Herbert Frank, secretary-treasurer; and Robert D. Dodd, assistant secretary-treasurer.

Continued



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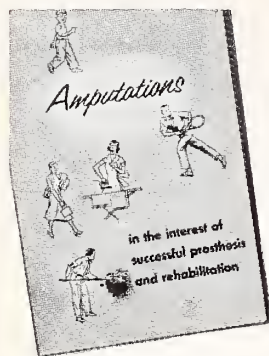
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DISTRICT, COUNTY

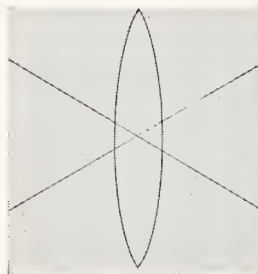
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Trustees include Drs. H. A. Schiller, G. C. Cook, G. W. Erickson, J. O. Hildebrand and R. B. Sanderson. Delegates are Drs. M. D. Whitlock, R. A. Ganser, D. L. Dunlap and W. D. Buchanan; their alternates are Drs. S. R. Phelps, W. J. McCraley, C. F. Martin and N. D. Sisson. Serving as censors are Drs. J. M. Thompson, N. N. Holtzman and C. E. Hamilton.

Committee chairmen are Drs. R. W. Holde-
man, program; B. J. Dolezal, public relations;
R. D. Dodd, public health and legislation; W. F.
Oren, civil defense; R. F. Reed, intra-profes-
sional relations; W. J. McCraley, entertainment;
R. W. Chamblee, accident prevention and poison
control; K. L. Cline, rural health; M. E. Fefer-
man, government medical services and insurance;
L. M. Bodnar, voluntary health; L. C. Bixler,
future doctors; H. J. Zimmer, industrial health;
E. M. Sirlin, project planning; and G. E. Gates,
liaison to county bar association.

White

Twelve members of the White County Medi-
cal Society heard Dr. Brice Fitzgerald discuss
slides on "Conditions of the Eardrum" at their
May 17 meeting. ▶



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"Where there is no vision the people perish." The Bible tells us this, and its truth has never been more apparent than in the world today. Vision is a prerequisite to planning, but White-Haines has been planning for vision for more than a half-century. Fine ophthalmic craftsmanship, prompt service, your utter confidence in the exacting execution of the lens prescription you write . . . that's the credo of White Haines. It took vision to plan for that ultimate, too.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—JUNE, 1961

Disease	June 1961	May 1961	Apr. 1961	June 1960	June 1959
Animal Bites	1074	806	527	918	1264
Chickenpox	418	602	613	335	142
Conjunctivitis	92	126	105	155	68
Diphtheria	0	0	1	0	0
Dysentery, Unspecified	8	26	25	10	7
Impetigo	86	61	79	86	69
Infectious Hepatitis	186	247	285	28	19
Infectious Mononucleosis	14	29	29	16	8
Influenza	257	333	437	393	217
Measles (Rubeola-Rubella)	861	1093	1022	1514	582
Meningitis, Meningococcal	3	4	5	6	2
Meningitis, Other	7	15	9	13	6
Mumps	710	1112	1001	473	248
Pertussis	2	2	3	21	44
Pneumonia	119	136	173	189	106
Poliomyelitis	0	1	1	2	7
Streptococcal Infections	392	465	691	429	285
Tinea Capitis	21	13	22	33	7



"What have you got for my nerves? Duncan Hines found a smudge on my nose!"

Wanted: Locations Physicians

Openings for General Practice

Randolph County—WINCHESTER—population 6,000. Farming and industrial community. 60-bed county hospital. Opening for partnership or associate practice with Dr. R. B. Engle, 210 S. Main Street, Winchester. Community can support an additional general practitioner. Contact Doctor Engle.

Spencer County—DALE—population 900 with a large surrounding area. Community can use the services of another practitioner, as one physician is limiting his practice to chiefly office work. Hospital located at Huntingburg which is 8 miles away. Contact Albert J. Wedeking, President, Dale State Bank, Dale, Indiana.

ST. MEINRAD—population 900. Located 16 miles from Huntingburg where hospital facilities are available. No physician in the town. Contact St. Meinrad Chamber of Commerce, St. Meinrad, Indiana. ◀

Association News

Eleventh Medical District Councilor's Report*

The onset of my term as Councilor was rather stormy. It began with the consideration of dues for the new building in Indianapolis. The local counties on occasion have voiced themselves rather heavily against it. I inherited a rather "black-sheep child" of whose conception I had no part. However, I might state that the building is now a reality and is being let for bids on the day of this meeting. Your society would appreciate it if those who have neither donated nor made a loan to this association, do so at their earliest convenience.

With the onset of this came the State Legislature in which the Council opposed the bill of the Legislature concerning corporate practice acts. While this may or may not have been in good taste or in good understanding, the Indiana State Medical Association is attempting to get a ruling from the Attorney General of Indiana concerning corporate practice provisions for clinics. If we are successful in this, it may be possible for clinics to participate without enabling legislation which was so greatly opposed by many of the rank and file.

I must report to you that the implementation of Kerr-Mills Bill in Indiana through the office of old age assistance, or the Welfare Department, did pass and is being put into action. I wish also to inform you that the osteopathic situation in the State of Indiana remains unchanged as far as true state policy is concerned. Until the AMA meeting in New York, where everyone is expecting the House of Delegates to instruct the Judicial Council to change its recognition of Osteopaths, no changes here may be taken. I must make each and every one of you aware that the national scene is somewhat dismal. The administration is using the Depressed Areas Bill, the Federal Judge Bill, and the Federal Aid to Education Bill as a lever on Congress to do the bidding of Mr. Kennedy. The fact is that Wilbur Mills, our best friend and chairman of the powerful Ways and Means Committee has been offered one of these Federal judgeships. Should he accept, it would elevate Mr. King from California who, of course, introduced the King-Anderson Bill. To further complicate matters for us the National Council of Christian Churches, (and who at last would have thought that the religion of America would turn itself against free enterprise), voted in February to approve the principle of Social Security Medicine and the Presbyterian As-

sembly which meets in Buffalo today through the 24th will have a resolution presented by its Council on Social Action and Education along similar lines. In addition to this we are now informed that the President has asked 34 Democratic governors to come to Washington, to bring two or three physicians with them from each state to testify before the Ways and Means Committee in an effort to discredit the American Medical Association in the eyes of the committee. This is about all from the Legislative point of view.

Project of Hope

It would be well for me to mention at this time this project called HOPE. Dr. Annis will be in French Lick on Saturday, May 20, 1961. He has a tremendous message. Also a member of the Ways and Means Committee will be in South Bend on Tuesday evening, May 23, at the Indiana Club; this should be a good meeting. I urge all of you who are able to attend, to please do so. Your Councilor has, in the short time which he has been in office, visited three other counties; once at Logansport for a rather happy party concerning their Auxiliary's work in the AMEF, another trip to Howard County concerning the controversy of the building fund and another one was an invitation to the Huntington County Society for the planning of this meeting. I wish to thank these counties for their hospitality. I should like very much to attend each and every county meeting within my district in the near future, and at least twice each year while I am Councilor.

I think that a Councilor's report without his feelings would be rather hollow. Constantly within the doctors' room at the hospital, at meetings, at parties where physicians gather, we hear the remark that the Indiana State Medical Association is wrong and opposed to this and opposed to that, that it never does anything but squabble and that it is run by a few of the hierarchy.

We hear the same thing of the American Medical Association. We hear the AMA is 100 years behind the times. In all I am very proud to hear that those who run the American Medical Association are 100 years behind the socialistic trends of today. I am glad to hear that they were from the era where people wanted to fight for the Union, where people were proud of the rights and privileges of this great country and were not asking this great country to support them, but only ask that it be a strong and wonderful nation made up of free people.

* Delivered at the annual district society meeting, May 17, 1961.

I wonder why these organizations are as corrupt as my fellow physicians would have me believe; why it is that they are such? And in thinking about this I come across the idea of who makes up this organization. I am very upset to find out that I am one of the members and that you are one of the members. I wonder why it is that everyone speaks of the old doctor, and the old country doctor and then gives a rather scathing remark concerning you and I. I think it is rather simple. Today we are noted for what? To turn patients by the hundreds away without any sympathy filled with wonderful drugs, which would have made our forefathers most envious, but completely empty of compassion, of love and of service to our fellow men. Old Doc wasn't noted for his wonder drugs—he was noted for his devotion to duty, for his thoughtfulness concerning his patients, for his love of his fellow men, for his willingness to sacrifice himself if necessary for them. I am afraid that many of our younger generation are not so noted.

It is high time that we look back 100 years in the practice of medicine and try to glean from that era that which placed the doctor with a little black bag upon a pedestal, that which made him the man of honor within his community, that which made him the man of integrity whose word was nearly law. What placed him there? How did he tumble from the high position? What gnawed at the pedestal until it crumbled? Was it the public? Was it the socialistic tendencies of our times? No, I am afraid it was not. I am afraid that those who sought to climb it began to eat away at its base finding that the chunks were better at the time, and that they would rather take a piece of rock from the bottom than climb to the top of its summit. And in gleaning their financial rewards and in hurrying and scurrying they forgot the patients.

Because We Forgot

So, today you and I fight a battle against socialism because we forgot the patients. Oh, it is true that socialism is here in many of the fields, but these too did the same. It is high time that we return to the visions we had before and during medical school where most of us thought that we would be fine and honored gentle-

men serving humanity without any regard to our own personal benefit nor our own personal health or wealth. Today, we return and find so few so devoted. Is not this the reason we are in trouble? Would it not be well if each and every man, woman and child in the United States of America could turn and say, "He is *my* doctor," and say it with such pride. Then all those who would send us down the road of socialism would find it a difficult job, because it would not be politically popular. Would not it be fine if every physician in this area were so fair, so square, so devoted to duty that the Eleventh District of Indiana could be pointed out as an ideal place to become ill.

My friends, even today the church has turned its back upon its heritage. A National Council of Churches has aligned itself with a socialistic phenomenon. If this has a reasoning, it is difficult to understand whether one be Protestant, Catholic or Jew. Have we in so many short years (200) forgotten the reason the pilgrims landed upon the eastern shores of this great country? Have we as physicians forgotten in a much shorter time, perhaps only 20 to 30 to 40 years why we obtained a diploma stating that we were doctors of medicine? As I look on the national scene, it took some 200 years, it has taken you and I but just a few. Let us return home from this meeting more dedicated to the care of the injured, sick and afflicted with a certain feeling for our fellow men no matter what our religion, and let us put together again the pedestal upon which our profession stands by building it with the stones of human kindness, love, affection, service and devotion to duty which our forefathers had. And in this respect we shall build a strong profession which no man can cast assunder.

Your Councilor will be glad to accept any suggestions or recommendations from this district at any time. It is my full desire to express in the Council the wishes of my district. This is difficult to do when one is not well aware of what those wishes may or may not be. I would vote as the majority requested even if I were opposed to what they ask. I represent you, the Eleventh Medical District, at each and every Council meeting. ◀

EUGENE S. RIFNER, M.D.

Councilor, Eleventh Medical District

ASSOCIATION NEWS

Continued

EXECUTIVE COMMITTEE

June 14, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D., Charles F. Gillespie, M.D.

Ralph Hamill, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of Dec. 31, 1960----- 4,309

1961 members as of May 31, 1961:

Full dues paying -----	3,632
Residents and interns -----	191
Council remitted -----	38
Senior -----	374
Honorary -----	3
Military -----	36

Total 1961 members as of May 31, 1961----- 4,274

Gain over last year ----- 28

Number of members as of May 31, 1960----- 4,246

Number of AMA members as of May 31, 1960 4,108

1961 AMA members: Dues paying ----- 3,504

Exempt, but active 646

Total 1961 AMA members as of May 31, 1961 4,150

Gain over last year ----- 42

Number who have paid state dues but not AMA
dues for 1961 ----- 124

Headquarters Office

On motion of Drs. Owsley and Stimson the secretary was instructed to purchase a new typewriter for the headquarters office.

Auxiliary expenses: The secretary presented bills from the president and the president-elect of the Woman's Auxiliary to the Indiana State Medical Association and asked what disposition was to be made of these bills. Upon motion of Drs. Glock and Owsley the secretary was authorized to pay Mrs. Rigley and Mrs. Kintner the amounts outlined on the statement from Mrs. Rigley and in the future all bills from the officers of the Auxiliary, to be paid by the Indiana State Medical Association, shall be submitted to the Executive Committee of the Auxiliary for its approval before being approved by the Executive Committee of the Indiana State Medical Association. If and when such bills are approved for payment by both of these bodies, the check from the Association shall be made payable to the treasurer of the Woman's Auxiliary, who will reimburse the Auxiliary officers.

Medicare supplemental agreement: The secretary presented a supplemental agreement covering the Medicare contract. It was approved for signature by the president, upon motion of Drs. Glock and Gillespie, providing the attorney cleared it for signature.

Treasurer's report covering Statements of Income, Expenses and Budget Balances as of May 31, 1961, for the headquarters office, *Journal*, Building Fund, and all funds, was approved on motion of Drs. Glock and Stimson.

Amendment to Bylaws: On motion of Drs. Owsley and Gillespie, the Executive Committee is to recommend that the Bylaws be amended in such a way that no expenditures of Association funds can be made that are not included in the budget without the appropriating body determining from where the money is to come.

Legislation

National: Hearing on H. R. 4222. Dr. Wood discussed the forthcoming hearings before the House Ways and Means Committee on H. R. 4222, asking the Committee to determine who should appear on behalf of the Association to present testimony if the Association is invited to appear personally before this committee. By consent it was left to the selection of Dr. Wood as to who shall appear before this committee.

Organization Matters

A copy of a letter addressed to John C. Nunemaker, M.D., Associate Secretary, Council on Medical Education and Hospitals, American Medical Association, by St. Catherine Hospital, East Chicago, Ind., was reviewed for the information of the Committee.

Letter received from the U. S. Treasury Department concerning a request for a ruling by the Allen County Medical Society, was read for the information of the Committee.

The president discussed his proposal to split the Seventh Councilor District into two districts. Following discussion, on motion of Drs. Stimson and Wilkens, the Executive Committee is to recommend to the Council that the Seventh District be divided into two districts, the additional district to be numbered District 14.

The president discussed the recommendation that the Association offer \$150.00 or some figure to all of the specialty groups to assist them in their programming for meetings to be held in conjunction with the annual convention of the Indiana State Medical Association. On motion of Drs. Owsley and Gillespie the Association is to offer each group \$150.00. The motion failed to carry.

On motion of Drs. Owsley and Glock, the secretary was authorized to offer the assistance of the headquarters office of the Indiana State Medical Association to the specialty groups in arranging their programs.

A resolution from the American Academy of Orthopaedic Surgeons was read for the information of the Committee and no action taken.

Letter of appreciation from April Shortz of Crawfordsville was read expressing thanks for the trip to the National Science Fair.

Letter from Mrs. Vance Hartke, thanking the Association for flowers, was read for the information of the Committee.

Letter from Senator Homer E. Capehart was read for the information of the Committee.

Continued

With proper medical management and adequate control of seizures, epileptic persons may lead productive, functioning lives.^{1,2} To implement this goal, many clinicians have come to rely on DILANTIN for outstanding control of grand mal and psychomotor attacks. For example, when DILANTIN was administered to 12 patients,³ all but one remained seizure-free in the hospital after the diphenylhydantoin blood level had reached its maximum. This patient experienced a single convulsion but had "...no further seizures during the subsequent three and

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(1) Carter, S.: *M. Clin. North America* 37:315, 1953.

(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.

(3) Buchthal, F.; Svensmark, O., & Schiller, P. J.: *Arch. Neurol.* 6:264, 1960.

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to *THE JOURNAL* of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington D.C.—The American Medical Association cited more than 50 reasons why the vast majority of the nation's physicians believe the Administration's medical care program would be "bad medicine for the people of the country."

The AMA's objections to the proposal were spelled out in a detailed, 91-page printed statement presented to the House Ways and Means Committee by Dr. Leonard W. Larson, Bismarck, N.D., president of the AMA.

The committee held two weeks of hearings (July 24-Aug. 5) on the Administration proposal (H.R. 4222) which would provide limited hospitalization, nursing home care and outpatient diagnostic services for social security recipients. The program would be financed by an increase in payroll taxes on workers, employers and the self-employed.

Dr. Larson declared that the Administration program would force upon Americans a system of health care in which the quality of medical care would deteriorate, in which quality would become secondary to cost.

He said American medicine is the best in the world, medical education unsurpassed and the qualifications of U.S. physicians unmatched.

"Ours is a dynamic system of health care and it works," he said. "The very fact that we now have 16½ million Americans 65 years of age and older proves that it works."

"Yet, this same system of medical care is now under attack. At a moment when American medicine is pre-eminent throughout the world, it is proposed that we adopt the very systems under which one European nation after another has lost its former leadership in medical science.

COST, ADMINISTRATION SECONDARY

"The staggering costs of such plans, the administrative problems they create—let these considerations be secondary," he said. "The important thing is to see, at close range, the disruption of the doctor-patient relationship; the delays in admission to hospitals; the time wasted in the overcrowded offices of doctors; the regimentation of medical practice; the effect of the program on medical research; the availability of medical facilities and personnel—in other words, medicine in action on a government-run, assembly-line basis."

Continued

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MONTH IN WASHINGTON

Continued

Dr. Larson said also:

1. Congress is being asked to plunge into a compulsory government-operated program of health care for certain of the country's elderly without knowing what even the first-year cost will be—whether \$1 billion or \$4 billion—and without any clear idea of the extent of the problem it seeks to solve.

2. The bill under consideration would give a single government official the power to "become the nation's czar of hospital care."

3. Contrary to statements of supporters of the measure that physicians' services are not included in the program, more than 50,000 doctors would be directly affected by regulations and controls exercised by government over operations and administration of hospitals.

4. Enactment of the program would "lower the quality of medical care available to the older people of the United States" because "it would introduce into our system of freely practiced medicine elements of compulsion, regulation and control" by government.

5. The Administration proposal is unnecessary in light of the true economic status of the aged and because of the spectacular rise of voluntary, private health insurance coupled with passage by Congress of the Kerr-Mills Medical Aid for the Aged Law last year and the existence of other public and private programs of aid to the needy.

6. Health care at the expense of the working people would be provided for millions who are financially able to pay for their own care.

SUGGESTS AGED ARE DEPENDENT ON SOCIETY

7. The legislation "proposes that we distrust the brains and capacities of today's Americans" because "it suggests that the aged—as an entire group—are not capable of looking after their own affairs and providing for their own needs."

8. Increasing costs of the program could impose such a financial strain on social security that the entire system could be jeopardized.

9. The Administration's bill is just as objectionable as the five similar health care proposals rejected by Congress since 1942.

10. The bill would violate "American ideals of independence, self-sufficiency and personal responsibility" by establishing a system in which medical aid would be provided not on the basis of need but on the basis of age.

Dr. Larson described estimates of the cost of the Administration program as "confusing."

The AMA president reminded committee members that HEW Secretary Abraham Ribicoff had told them that "a closer study" had revealed it

Continued

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MONTH IN WASHINGTON

Continued

would be necessary to increase the taxable wage base from the present \$4,800 to \$5,200, rather than the \$5,000 fixed in the bill when it was introduced.

He also pointed out that HEW originally had said nursing home services during the first year of operation of the Administration scheme would cost \$9 million.

But in May, Dr. Larson said, HEW officials reported the figure as "unrealistically low" and lifted it to "somewhere between \$25 million and \$255 million."

"Obviously the estimate is something less than precise," Dr. Larson said.

The AMA president said that supporters of the Administration proposal have built their case on five false premises: 1) that the sociological problems of older people can be solved through legislation; 2) that most, if not all, of the aged are in poor health; 3) that most, if not all, of the aged are verging on bankruptcy; 4) that the problem of the aged in financing their health costs will get worse before it gets better, and 5) that voluntary health insurance and prepayment plans, private effort and existing law will not do the job that needs doing.

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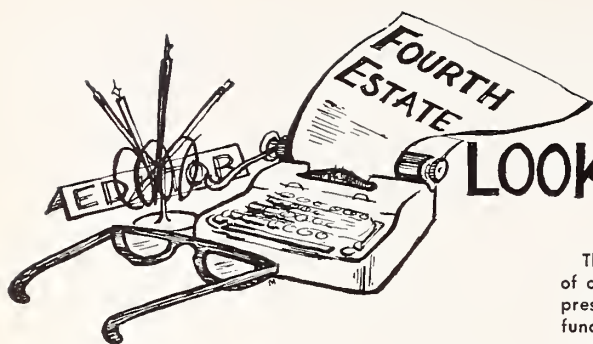
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

What Price Aspirin?

Senator Estes Kefauver of Tennessee has begun to press the legislative project for which his sensational committee hearings on drug prices were the build-up.

The target of his proposed new law is far beyond the price of drugs. The drug industry is just the springboard. The Kefauver bill, offered as a plan to "spur competition" and bring lower drug prices, would have much farther-reaching effects.

The Kefauver bill is a direct attack on the patent system. And it is a direct attack against the idea that the operators of the free market system—the people who make things and the people who buy them—should decide whether or not a new product is to be sold.

The bill would provide, bluntly, compulsory licensing of drug patents after three years from the date of the patent application. The inventor of a new drug would be compelled, after this initial three-year period, to give all his essential knowledge about the drug to any manufacturer who might want to make it and compete with him in its sale. He would have no control over the selection of competing makers, over the quantities they might make and place on the market, or over the price. His only compensation would be the right to charge a royalty based on the competing manufacturer's selling price.

Doubtless this would bring a surge of new competition in the making of the more popular and profitable of patented drugs now on the market. The prices of some such drugs probably would drop. But under such conditions, who could afford to finance the continuing search for new "miracles" in the drug industry?

Another section of the Kefauver bill would prohibit placing a new drug on the market unless

the Department of Health, Education and Welfare decided it was a good idea. The commissioner of the Food and Drug Administration would be empowered to decide whether the new drug was sufficiently different and useful to justify offering it to the public, and whether it was sufficiently "efficacious." If the commissioner were satisfied on these points, the drug could be licensed for manufacture and sale. If not, he could simply turn thumbs down and that would be that.

These amendments to the anti-trust law, the patent code and the food and drug laws are proposed for the drug industry only, on the basis of an argument that the drug industry is special, different from other industries, because its products are vital to the health and well-being of people. But there are all kinds of industries which fit that argument. Food is also vital to the health and well-being of people. Should food patents therefore be under compulsory license? And should the government bureaucracy decide whether a new food product is worth offering to the public? The traffic lights at a busy intersection are vital to the safety and well-being of people. Should the same rules apply to the patenting and marketing of new traffic signal developments?

When the Senate takes up this proposal, it will not be taking up just a question of how much profit a pharmaceutical house is entitled to make on a new drug it perfects. It would be bad enough if Congress should take it upon itself to decide that question. But this proposition is much deeper. It is an attack on the basis of the American economic system.

What Senator Kefauver proposes is a renunciation of the principles of free enterprise with which this nation was built. It has always been

Continued on page 1254

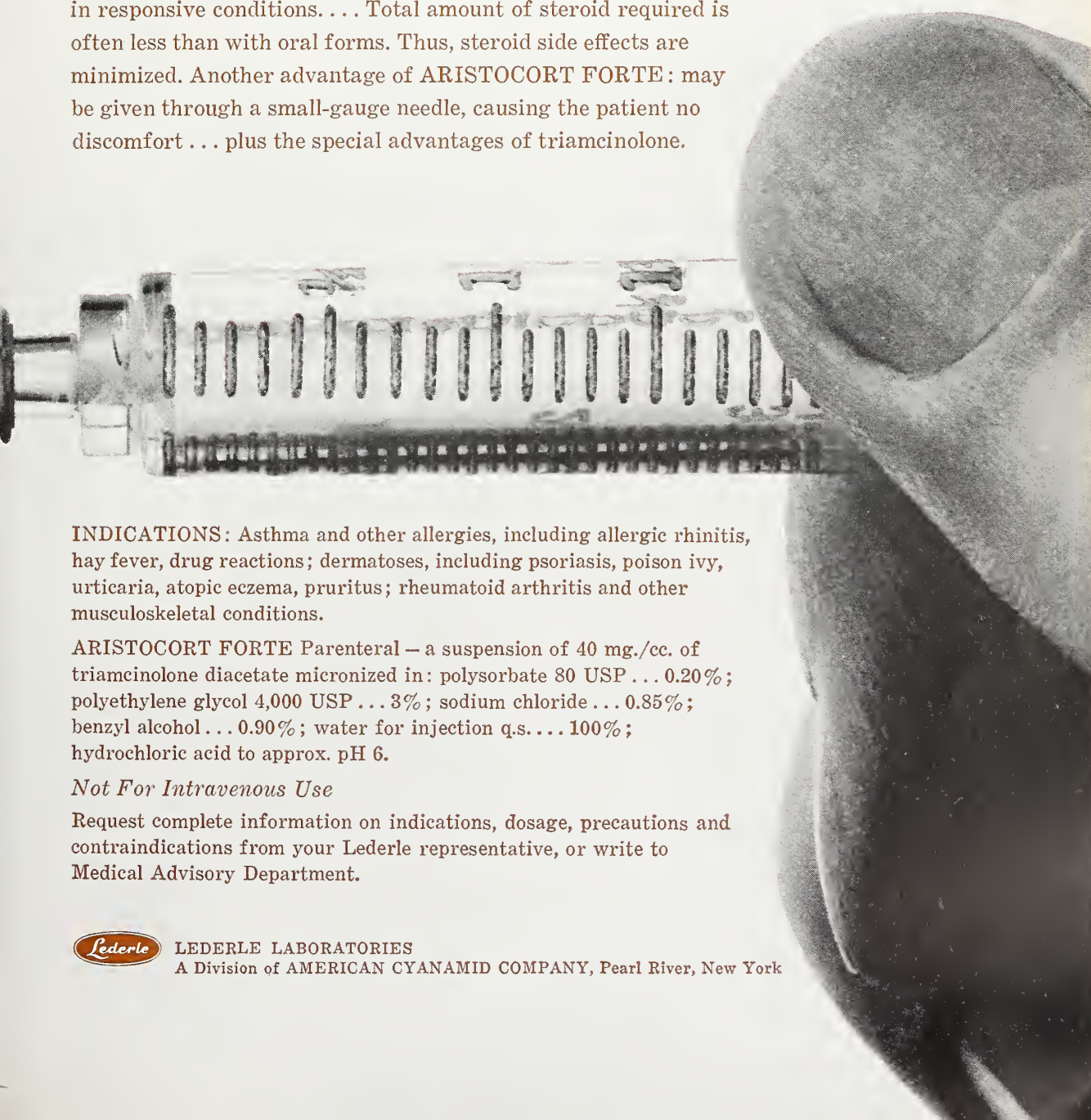
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FOURTH ESTATE

Continued from page 1250

an essential element of the American system that the one who discovered a new product or a new way to produce a wanted service was entitled to reap the profits of selling his discovery, and to be protected against the theft of it. Another essential element has been the freedom of anyone who wants to take the risk to try to produce and market something he has discovered, and the freedom of the rest of the people to buy it or leave it alone.

Take those things away, and the genius and strength of the American economy will begin to wither.

The Kefauver bill should be fought for its true nature. It is not just a drug bill. It is a bill that strikes at the foundations of American business.

Indianapolis Star
July 15, 1961

His Tip on Safety—Just Ask

Unless car owners demand automobile safety devices, they won't get them, a police sergeant who knows, said today.

Sgt. Elmer Paul is no ordinary proponent of the auto safety program.

He's the man directly responsible for the padded dashboard, the deep-dish steering wheel and the pop-out windshield in today's cars.

He and the men working with him are responsible for the drive to have all cars equipped with safety belts.

Sgt. Paul is head of the Indiana State Police Auto Crash Injury Research program that works hand in hand with Detroit manufacturers to make cars as safe as possible.

He and Sgt. Gerry Howard, his assistant, are in Winnipeg to tout car safety by supervising a safety exhibit at the Red River Exhibition next week.

By the use of slides and actual demonstration of "stay-closed" doors, safety belts and the shock-absorbing steering wheels, they hope to educate Manitobans to be conscious of all that can be done to prevent serious injury in traffic mishaps.

Their visit here has been sponsored by the Manitoba Medical Association.

"We say you are going to crack up," Sgt. Paul said in an interview, "and we ask how we can bring you back alive."

But no matter how many safety devices are available, he said, if the people don't ask for them, the car manufacturers won't voluntarily spend money on them.

"Truthfully, industry is concerned with safety. But the public has to ask for it."

Sgt. Paul joined the Indiana State Police 20 years ago—"as a lark while waiting for another job." He had been repairing wrecked cars for a living since his high school days.

In 1949, a new program under his guidance took shape in Indiana. He and his 12-man educational staff studied reports of more than 4,000 auto accidents. They weren't interested in the cause of the crashes. They wanted to know what caused the death or injury of the victims.

Their findings were sent to car manufacturers who began taking an interest in the project in 1952.

The Winnipeg Tribune
June 22, 1961

The Polio Vaccine Controversy

Kokomo people will hope that the child who was reported last week as the first polio case here this year will recover. The little boy and his parents have the best wishes of the community.

Last year Kokomo had only one polio case, and citizens will remember the years before the Salk vaccine when there were a good many cases and fear of the disease was widespread. Since Dr. Salk gave his great discovery to the world, this apprehension has faded.

The fact that people no longer fear polio is coupled, however, with the danger of indifference to getting children vaccinated against it. Health officials urge parents to be sure their children have the shots.

The polio picture has been complicated by a renewal of the controversy over the relative merits of the Salk killed-virus vaccine and the Sabin live-virus serum. Dr. Salk has denied assertions that his vaccine is only "second best," and points to the fact that for the week ended July 8, there were only ten cases of polio reported for the entire country, of which seven were paralytic, as against 577 for the same week

Continued on page 1258



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Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at
bedtime. May be habit-forming. Federal law permits oral
prescription.



Literature on request

ENDO LABORATORIES
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FOURTH ESTATE

Continued from page 1254

in 1954, the year before the Salk vaccine was introduced. The data also show that for the first 26 weeks of 1961 the total number of polio cases for the entire country was 247 as against a total of 4,934 for the first 26 weeks in 1954. These figures show, he states, that if mass vaccination with the Salk vaccine would be made, polio as a disease would be completely wiped out before the live-virus vaccine became available.

The Sabin vaccine, it is reported will not become available before October, when the current polio season will be over. Meanwhile everyone below the age of fifty should protect himself by the Salk vaccine.

Kokomo Tribune
July 24, 1961

Good for a Laugh

Some of our best friends are socialists. In fact, they're shouting socialists with whom we've broken many an argumentative lance. But the clash of convictions is good-natured; we always agree that socialism is what we're talking about, whatever name it may go by in the political market place.

Just the other evening, we were discussing "socialized medicine." Our friends didn't flinch at the phrase. No, it was agreed that once the government began taking care of the health of some of the people, political pressure ultimately would require the government to minister to all the people. Anything short of that would be rank social injustice.

In the course of our amicable debate, it was decided that the essential elements of socialized medicine (or whatever polite name the politicians gave it in the beginning) would be compulsory coverage, regardless of individual wish or need, and necessary government control of the huge outlays of public money required by such broad coverage. Soon or late, the government would have to supervise hospitals, nursing homes and medical practitioners—anything and anybody handling the public business.

There was a footnote to our argument a couple of days later, when one of our friends called to ask if we'd seen what Welfare Secretary Ribicoff had said in Washington. Testify-

ing in behalf of the Administration's plan to provide medical care for 14 million elderly Americans under Social Security, Mr. Ribicoff was hotly indignant that anyone should call the scheme "socialized medicine." Why, the Secretary said he personally had reviewed the plan and removed "all the elements which could be called socialistic." It gave our socialist friend a good laugh.

Wall Street Journal
July 31, 1961

A Fourth Of Us Get Hurt

For long years we have heard, quite properly, the steady note of alarm struck over huge traffic death tolls and other accident fatalities. All too little is the massive total of accident injuries impressed upon us.

From all accident causes, about 90,000 Americans lose their lives every year. Not much less than half are the result of automobile mishaps.

But nearly 47 million persons suffer injury in accidents each year. This means that more than a quarter of the nation's population gets involved. It seems almost incredible.

The U. S. surgeon general, Luther Terry, points out, too, that many of these millions of injured are crippled, disfigured, made dependent on wheel chairs and crutches, even confined to bed for life.

The worst of it is that a surprisingly high percentage of accidents happen to individuals who are approaching or enjoying their most productive years.

Surely we as a people can do a vastly better job than this in protecting our own life and limb.

Kokomo Tribune
July 3, 1961

Our Active Health Department

The city-county health department here is now armed with a new weapon for getting rid of weeds and other rank vegetation inside the city limits.

It can levy a \$5 charge against any property owner who fails to cut his own weeds. This charge is for properties 50 feet by 132 feet in dimension, and a higher bill can be assessed if properties are larger than that.

Continued

The cigarette that made the Filter Famous!



It's true. Kent's enormous rise in popularity—with all the attendant magazine and newspaper stories—really put momentum to the trend toward filter cigarettes!

So, Kent is the cigarette that made the filter famous. And, no wonder. Kent's famous Micronite filter is made from a pure, all-vegetable material. A specially designed process at the P. Lorillard factory compresses this material into the filter shape and creates an intricate network of tiny channels which refine smoking flavor.

Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.

That's why you'll feel better about smoking with the taste of Kent.

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FOURTH ESTATE

Continued

A revised ordinance, now in effect, empowers the city to levy the charge through a lien on a property owner's taxes.

This is no harsh regulation, but a sensible and necessary step in the health department's efforts to make Kokomo a clean, healthful community. Weeds do constitute a health hazard. They can harbor mosquitos and no one needs to be told the menace to health that these insects pose. Pollen-shedding weeds can greatly increase the discomfort of hay fever sufferers, too.

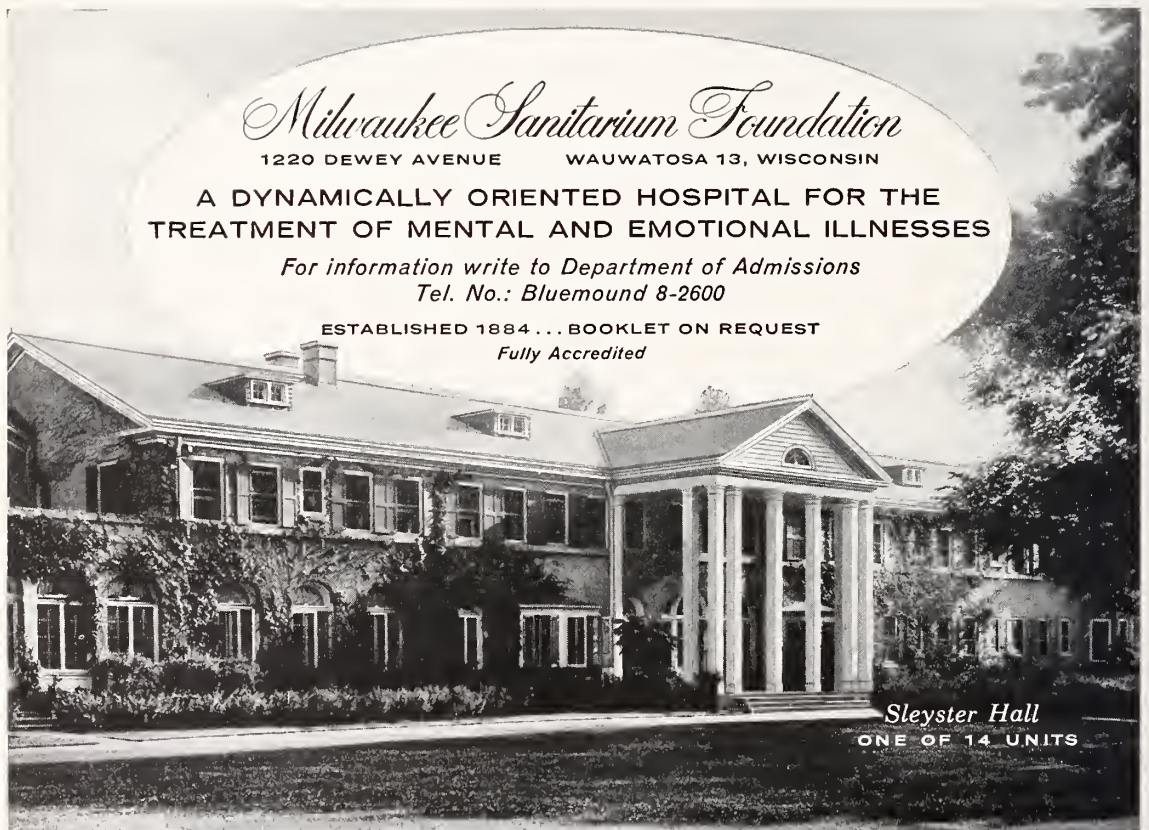
Our community is served by a vigorous health department, which is interested in cleaning up unsanitary conditions, and we as citizens should be appreciative. The department inspects milk suppliers, restaurants and food markets, and has the power to require that these places meet standards that safeguard the processing and serving of food. All one needs to discover how much these powers have done to clean up conditions where food is handled is to examine the records of some of the cases that the health de-

partment has corrected. There are instances where conditions were so unsanitary as to be incredible. It speaks well of the city's food establishments that today the majority of them are clean and a credit to the community.

The health department is now asking for passage of an ordinance which would give it authority to order unsanitary conditions eliminated in certain residential properties. This is not a move to obtain the right to start condemning sub-standard dwellings on a wholesale scale. It is an effort to provide the health officer a guide to go by when his attention is called to unwholesome conditions.

Recently one of the department inspectors was called to check on an uninhabited house in which flies and rats, together with other appalling conditions, were found. It is such conditions that the department wants to correct, and the community should be grateful that it has a health office that is that much interested and is active.

Kokomo Tribune
June 12, 1961



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Surgical Treatment of Back and Leg Pain Persisting After Adequate Disc Surgery

*L. W. FREEMAN, M.D.**

Indianapolis

DURING WORLD WAR II, many surgeons encountered clinical entities which could be classified under the original Silas Weir Mitchell¹ definition of causalgia. To his listing of severe pain following partial injury of a nerve accompanied by vasomotor and trophic changes and exaggerated by emotional stimuli, modern surgeons have added: relieved by appropriate sympathectomy. Our experience with cases not conforming to the classic description led Shumacker and me to investigate certain aspects of the conduction of painful impulses via the sympathetic chain.²

Extending this general interest into the field of partial nerve injury, represented by the nerve deficits imposed by protrusion of degenerated intervertebral disc material, it is now apparent that some of the continued pain problems following adequate routine surgery can be classified properly as causalgia. The inference is, of course, that the definition of causalgia need no more conform to a given case of Mitchell's than would the average case of Guillian-Barré conform to

either of their original descriptions. The following case is illustrative:

Case Example

A 43-year-old white female was treated at several hospitals by a variety of surgical procedures which included removal of degenerated disc, subsequent re-excision of disc, casting, re-exploration and wrapping of nerve root with membrane, and re-exploration with bone graft. By her statement on admission, verified through the other physicians, the signs and symptoms were quite confined to the fifth lumbar root on the right. In addition, she had mild meralgia paresthetica on the right. Under total spinal anesthesia to the eighth thoracic level, all pain vanished. Under a one-legged spinal, the pain disappeared. Lumbar sympathetic block relieved the pain on two occasions. However, under manipulation during the spinal anesthesia, it was noted that the bone graft (as suspected from the roentgenograms) was loose.

It was decided to remove the bone graft and to section the sensory division of the nerve root first. No great degree of relief was obtained and

* From the Department of Surgery, Indiana University School of Medicine.

she was re-admitted a year later, with aching pain on the left as well. Psychiatric evaluation indicated dependency and need, but would not eliminate somatic factors. The right fifth root showed minimal muscle loss and marked hypesthesia. The foot and leg were cold and pale, as compared to the left. Unilateral right lumbar sympathetic block provided relief on the right, but the left seemed to pain more. Bilateral lumbar sympathetic block gave complete relief on three occasions with 1% Xylocaine, but not with saline on one occasion.

Bilateral lumbar sympathetic ganglion excision from the first to fourth lumbar was then done. This was followed by relief of the pain in its entirety in both legs. However, she complained of sensitivity over the distribution of both lumbosacral nerves. Six months later, the anterior thigh dysesthesia had largely disappeared, all pain was absent from the back and right leg, but there had been two bouts of left sciatic "shooting" pain.

Discussion

This representative case is one of those with difficulties originating at the outlet of the nerve root and backward into the spinal canal beyond the reach of the ordinary disc herniation. Most of the cases we have seen have had prior relief of the presumed somatic portion of their pain—the sharp, stabbing, shooting, electric spurts which are exaggerated by straining maneuvers. Some still listed the shooting character of the pain, but indicated that the pain was dull rather than sharp. In these, there was generally evidence of intraspinal change such as arachnoid thickening or complete plastering by adhesions of the posterior roots.

The cases under discussion are representative of those who have had partial "permanent" injury to the nerve root. They come from the approximately 15% who fail to gain complete relief after adequate discectomy and decompression of the nerve root.

This group fits in nicely with those patients with pain from intraspinal injury previously reported.³ In these patients, it was observed that a moderately low spinothalamic section would abolish somatic pain, but would leave burning pain which could be abolished by higher section. These findings fitted the thesis that pain afferents existed in the sympathetics.

Most of these limbs showed signs of marked

vasoconstriction—paleness and coldness. The reversal of these signs, coincident with abolition of pain, would serve as a strong indication that efferents had been sectioned—as indeed they have—but the afferent arc is also sectioned. As such, it is impossible to determine what the mechanism might be from these observations. For axial or closely para-axial structures, innervation is often bilateral and multisegmental. One would assume that bilateral sympathetic denervation would be needed.

Similar pains to those complained of in the chronic disc syndrome are seen in cauda equina and even spinal cord injured patients. When the roots alone are involved, it is usual for the patient to have intense lancinating pain relieved only by anterolateral spinothalamic tractotomy.³ If the cordotomy did not cover the entire trunk sympathetic supply (up to the fourth thoracic dermatome), a vaguely localized burning pain would remain.

The best method for investigating this problem is to administer spinal anesthesia to the fourth thoracic dermatome without suggestion as to its effects (spinal test). If the pain is not abolished, the psyche should be subjected to careful examination. Next, a "one-legged spinal" (or low spinal if the pain is bilateral) is given to differentiate somatic pain. Finally, a lumbar sympathetic block is done to evaluate the sympathetic pain. The sequence is used in this fashion to eliminate the possibility of exaggerated effects, for chronic pain sufferers all appear to have psychic overlay of some degree.

The operative removal of sympathetic ganglia must be radical, for the classical lumbar sympathectomy (lumbar two, three and four) only tends to get the leg below the knee and will provide little or no relief, even though the lower lumbar and upper sacral somatic roots are involved. Probably the surest operation would go higher than the tenth thoracic, using the Peet or Adson approaches.

One might conjecture upon the mechanisms involved. Schwartz⁴ relates a harrowing experience in operating upon another neurosurgeon where the postoperative condition involved more pain and greater somatic loss. On hurried re-exploration, he noted that the involved root was extremely pale, but otherwise not in difficulty. Subsequently, the pain and somatic loss disappeared. Most of the roots in question have

scar of varying degrees. Section of the posterior division of the root often will not provide relief.

Thus, the mechanism probably centers about painful impulses arising from within the nerve (Figure 1). Movement initiates this pain, indicating a possible traction mechanism. Increasing spinal fluid pressure can increase the pain, indicating that pressure may be a factor. Recumbency often provides full relief of the pain, indicating a possible contribution of the cardiovascular components.

Whatever the many elements might be, they could have a common answer if one considered the intrinsic innervation of the nerve or the intrinsic blood supply of a nerve. The threshold for the initiation of local pain in a nerve is usually lower than that for production of projected pain. Vascular supply of an injured nerve differs considerably from that of normal nerves. Such vessels are under sympathetic control and it is not difficult to visualize the same pain initiating stimulus such as stretching bringing about vasoconstriction of the vessels of the nerve and thus ischemia of the nerve. This would induce lasting pain with the added potential of inhibiting somatic function.

Summary

Residual pain after adequate disc surgery may be similar to causalgia and will respond to appropriate sympathetic denervation.

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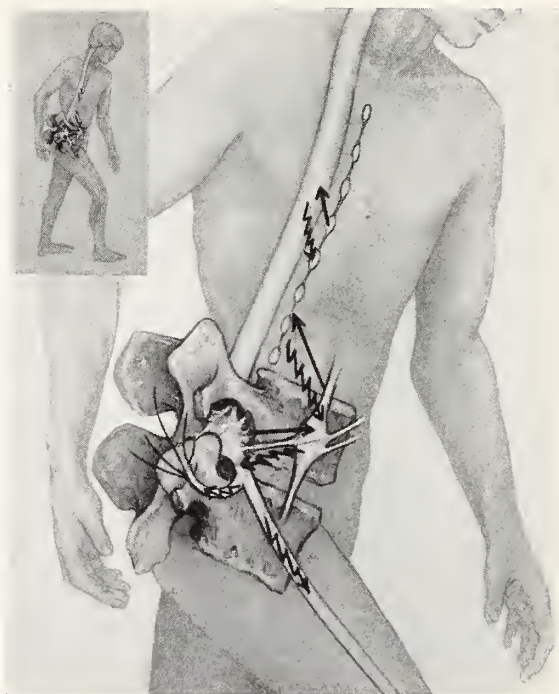


FIGURE 1

CONNECTIVE TISSUE scarring in and around the nerve root at the foramen and over the disc produces ischemia upon movement or straining procedures. The local reflex arc to the sympathetic ganglion and back induces further ischemia of the root, giving projected pain down the leg and into the back, reaching the level of consciousness through pathways entirely within the sympathetic nervous system.

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Sheehan's Syndrome

JAMES R. DOTY, JR., M.D.

RICHARD W. STANDER, M.D.

Indianapolis*

SHEEHAN'S SYNDROME is represented by the condition of panhypopituitarism secondary to obstetric hemorrhage. Although the association between pituitary hypofunction and obstetric hemorrhage was first noted by Glinski in 1913, the latter thought the pituitary disorder to be primary and responsible for uterine atony and subsequent excessive blood loss.¹ However, the following year Simmonds wrote the first of several reports dealing with hypopituitarism and, along with infection and intracranial neoplasm, listed postpartum hemorrhage as one of the causes.⁵ He stressed the emaciation frequently associated with pituitary hypofunction.

In 1939, Sheehan published the results of a study of eight patients with postpartum hemorrhage resulting in decreased pituitary function and his later publications dealt with clinical and histologic features of this particular form of Simmond's disease bearing his name.^{2, 3, 4} He is responsible for our current concepts of the disorder. Sheehan considered the pituitary gland to be extremely vulnerable to changes in its vascular supply because of hyperplasia accompanying pregnancy. Under these circumstances, hypotension usually initiated by excessive blood loss may result in thrombosis of the pituitary arterial blood supply with resultant necrosis of pituitary tissue, decrease in its secretory capacity

and consequent decreased function of the pituitary gland's target organs.

Progressive Manifestations

The first manifestations of the condition may be fever, vasomotor collapse and failure of lactation in the early puerperium while other signs and symptoms may be absent at this time. Apathy, asthenia, sensitivity to cold, slowing of speech and mental processes, and loss of libido develop after a latent period of variable extent. Teter states that the condition should be suspected in the presence of the triad of (1) postpartum hemorrhage, (2) absence of lactation, and (3) continued amenorrhea.⁶

Physical findings in advanced cases parallel the decreased function of gonadal, thyroid and adrenal tissue suffering the loss of pituitary tropic substances. Atrophy of breast tissue, depigmentation of nipples and areolae and atrophy of vulva, vagina and uterus are common findings. A waxy pallor of the skin is often present. More variable findings include the loss of pubic and axillary hair. Weight changes are also variable; myxedema may occur late in many cases with concomitant gain in weight while emaciation and weight loss ultimately occur in a fourth of the patients. Facial appearance may be that of myxedema, premature aging or a combination of the two. Eyebrows are frequently thin, especially in the lateral aspects but skin pigmentation of the Addisonian type is rare.

* From the Department of Obstetrics and Gynecology, Indiana University Medical Center and Marion County General Hospital.

Laboratory studies are usually reflective of decreased function of the pituitary and its dependent organs. The basal metabolic rate is ordinarily in the range of -25 to -35% early in the disease, while values obtained later may be even lower. Values for protein-bound iodine and radioactive iodine uptake studies are also indicative of the hypometabolic state secondary to hypophyseal hypofunction. The initial hemogram often indicates hypochromic anemia of a moderate degree but a normochromic macrocytic anemia may develop later if severe hypothyroidism ensues. Total leukocyte count tends to be low, with values ranging from 4,000 to 6,000.

Differential white cell counts may show eosinophiles ranging from normal to as high as 12%. Total serum cholesterol levels are frequently elevated while blood urea nitrogen determinations yield normal values. In typical cases, fasting blood sugar levels are usually low and glucose tolerance determinations demonstrate relatively low hourly values with flattening of the overall curves. These patients are sensitive to insulin to the degree that insulin dosages should be reduced if insulin tolerance tests are employed to assess adrenocortical function. Urinary excretion of 17-ketosteroids is markedly diminished in most instances, but can usually be increased by administration of ACTH. Values for urinary gonadotropins and estrogens are low.

Case Presentation

The patient, a 29-year-old white female, was last delivered at Marion County General Hospital, Sept. 3, 1958. Complications of six previous pregnancies included mild preeclampsia with one pregnancy, spontaneous abortion at 12 weeks gestation during another and, in 1954, delayed postpartum hemorrhage due to retained secundines occurred following delivery of twins. Perforation of the uterus occurred at the time but the patient's recovery was without complications.

The seventh and last pregnancy was complicated by uterine bleeding in the second and third trimester, necessitating three antepartum hospital admittances. Placentography and vaginal examination three days prior to the onset of spontaneous labor failed to indicate the cause of bleeding. Following a two-hour first stage of labor, a 7 pound, 12 ounce living male infant was delivered by low forceps. After a 30-minute third stage, mild vaginal bleeding prompted

manual removal of the placenta. The latter was found to represent a severe form of placenta septuplex and was comprised of several small lobes separated one from the other by membranes. Although some of the lobes were separated from the uterus with difficulty, subsequent manual exploration of the uterus failed to reveal remaining placental fragments.

No Contractions; Hemorrhage, Shock Ensue

Despite intravenous oxytocin infusion the uterus failed to contract and severe hemorrhage and shock ensued. For 50 minutes the patient was hypotensive with systolic blood pressures of 90 mm. Hg. or less. For 15 minutes of this time, blood pressures were unobtainable. Plasma expanders, whole blood and vasopressors were used to combat shock. For three hours following the episode of hypotension, systolic blood pressures remained at 95 mm. Hg. and marked tachycardia was present. Because of continued vaginal bleeding of a moderate degree, curettage was performed resulting in the removal of additional placental tissue. At the conclusion of the curettage, blood pressure was 100/65. Whole blood and vasopressors had been administered throughout the procedure.

For the next three days, it was necessary to utilize vasopressors and cortisone to maintain normal blood pressures despite adequate blood replacement as attested by repeated hemograms. After restoration of vasomotor stability, the postpartum course was further complicated by excessive vaginal bleeding of an intermittent nature, endometritis and thrombophlebitis of the left leg. Further transfusions were given, as well as antibiotic therapy, but anticoagulants were not employed. The patient became afebrile on the thirteenth postpartum day only to suffer a profuse vaginal hemorrhage and curettage was repeated. During the procedure, the uterus was perforated, hemorrhage continued and a subtotal hysterectomy was performed.

The cervix was not removed because of a rapid deterioration of the patient's condition during the abdominal procedure. Postoperative course was without further complication. The pathologist reported that a necrotizing endometritis was present in the surgical specimen. Lactation did not occur during hospitalization although suppressive therapy was not accorded. The patient was discharged from the hospital on

Sept. 25, 1958, the twenty-second postpartum day.

Shows Weakness, Weight, Libido Loss

The patient was next seen February 5, 1959, with complaints of weakness as well as loss of weight and libido. She was asthenic, slow of speech and appeared older than her 29 years. Weight was 95 pounds, a 10-pound loss from weight at discharge from her previous hospitalization. Blood pressure was 88/44 and pulse rate 44; neither were altered by change in body position. A moderate amount of axillary hair was present but the patient stated that she had not had to shave in this area. Pubic hair was less dense than before delivery. The skin was extremely dry and some superficial desquamation was present. The vaginal introitus was much smaller than expected for her degree of parity while the vaginal mucosa and cervix appeared atrophic.

A tentative diagnosis of Sheehan's syndrome was made on the basis of history and physical examination and hospitalization was urged for further study and treatment. Although the patient seemed to understand the purpose for hospitalization, she appeared reluctant to be admitted. Admittance was accomplished a week later at which time the laboratory findings were as follows.

The vaginal smear indicated extreme estrogen deprivation, 70 to 80% of cells present being of the basal type. No urinary gonadotropin could be detected at 12 hours, indicating a distinct failure of the pituitary to elaborate FSH in normal quantities.

Assays for adrenal function yielded values for 17-ketosteroids of 3.2 mg and 2.8 mg/24 hours on 2 occasions while concomitant values for 11-oxysteroids were 2.7 mg and .7 mg/24 hours. Stimulation with 25 units of ACTH given intramuscularly raised the 24-hour excretion of 17-ketosteroids to 6.5 mg on one occasion. Electrolyte determinations demonstrated values for potassium of 4.7 meq./100 cc, sodium 137 meq./100 cc, and chloride 114 meq./100 cc. The fasting blood sugar was 56 mg% while a two-hour postprandial value was 66 mg%.

Two determinations of the basal metabolic rate yielded results of -40 and -35% while protein-bound iodine was found to be 4.1 and 3.1 gamma/100 cc on 2 occasions. Serum cholesterol was 294 mg%.

The initial hemogram included a hemoglobin of 12.8 g.%, a white blood count of 6,600 with a differential count of 31% neutrophils, 68% lymphocytes and one percent eosinophiles.

X-ray examination of the skull and chest failed to reveal significant abnormalities.

The diagnosis of Sheehan's syndrome confirmed by laboratory evidence of gonadal, thyroid and adrenal hypofunction, the patient was started on prednisone, 5 mg daily and discharged from the hospital. For three weeks there was steady improvement with increasing appetite and vigor as well as elevation of mood. At this point, the patient ceased taking her medication and a week later came to the hospital requesting admission. She was confused and withdrawn. A few days after readmission, she became unmanageable on the open ward and was transferred to a seclusion room on the psychiatric service. Psychologic testing was attempted but no specific psychiatric diagnosis was suggested by the test results.

The patient refused to eat for several days and was maintained at first by parenteral fluids and later by nasogastric tube. Dessicated thyroid and prednisone were added to the feedings. She gradually improved and was returned to the open ward where medication consisted of cortisone acetate 12.5 mg t.i.d., dessicated thyroid 15 mg daily and methyl testosterone, 5 mg sublingually twice daily. Improvement continued and the patient was discharged from the hospital, May 1, 1959.

She has been under continued observation as an out-patient. Cortisone dosage was altered from time to time, but currently her average daily maintenance dose is 37.5 mg daily. Thyroid has gradually been increased to 30 mg daily. She still receives 10 mg of methyl testosterone a day. Under this regime, she is able to do housework, has gained 10 pounds and there has been some increase in axillary hair. Her affect remains somewhat flat and she fatigues easily. There have been occasional episodes of "flushing" attributed to estrogen deprivation.

Discussion

This case of Sheehan's syndrome includes many of the features characteristic of the disorder. Obstetric hemorrhage and profound shock were quickly followed by evidence of adrenal failure in that steroid therapy and vasopressors were required to maintain blood pressure in the

early puerperium. Absence of lactation was also a suggestive early sign of hypophyseal inadequacy. Only five months after delivery the patient presented herself with weakness, apathy, weight loss and signs of ovarian failure. Laboratory data supported the diagnosis of adrenal, thyroid and gonadal hypofunction; however, further study indicated that failure of pituitary stimulation was responsible for decreased function of the adrenal glands and ovaries rather than primary disorders of these structures.

The basic components of therapy for a generalized pituitary deficiency are glucocorticosteroids and thyroid hormone. Testosterone seems to work well in conjunction with the glucocorticoids to compensate for the adrenal insufficiency as well as producing a generalized anabolic effect. Thyroid hormone, given alone, produces little improvement and, if given without glucocorticoids, may precipitate an adrenal crisis. Steroid

dosage may be regulated by subjective improvement of the patient but should be increased at times of stress, i.e. infection, trauma, anesthesia, etc. Exogenous estrogens may minimize atrophy of estrogen-dependent structures, but are not essential in primary management.

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Remedy Of Choice

Many years ago I was asked by an insurance company to make a special examination and report on the continuing illness of one Joe ———. I have forgotten the details of this case but recall he had had arthritis of the knee joints followed by ankylosis. It seems medication was of no benefit.

Joe made his home with a married sister Mrs. Q——— who remarked that she wanted Joe to try some liniment her husband had used with success some years ago. This mixture was so offensive her brother would not consider it.

To prepare, fill a six-ounce jar with fishing or angle worms, packing them in firmly. Set the jar in a "cool dry place and shake night and morning." After two weeks' time the "cream" is ready to use. Apply to knee joints morning and night.

I asked Mrs. Q——— if the worm lotion had been effective in her husband's case. She said "very" but they had to stop it as it made his joints "too limber," so limber that his knee joints bent backward as well as forward "like them long legged birds we once saw in the Cincinnati Zoo."

H. H.

He is a particular entity; his institutionalization need be educational as well as domiciliary.

Treatment of the Alcoholic

DONALD W. BRODIE, M.D.*

Indianapolis

THE PAST 29 YEARS have produced what may be termed a revolution concerning our thinking about alcoholism, and also, in turn, our unusual success in the arrest of alcoholism in a growing population. Major factors in this change of attitude and encouraging results have been:

- (1) The Center of Alcohol Studies started at Yale University, 1930—by Dr. Howard Haggard.
- (2) Alcoholics Anonymous, started in 1935, a fellowship of men and women who share their common experiences, strength, and hope which may, in turn, allow them to arrest their disease.
- (3) The National Council on Alcoholism was organized in 1944.

All three of these forces, each in its own way, has resolutely accepted the fact that the alcoholic is a sick person, that the alcoholic can be helped, and that the alcoholic is worth helping.

These facts have enabled the alcoholic to gain

insight into his personal problems and give him the examples of recovery. Thomas Trotter, a British Navy physician, wrote in 1788: "Are not habits of drunkenness more often produced by mental affections than corporeal diseases? The seeds of this disease (the habit of inebriety), I suspect, like many others, are often sown in infancy. I do not merely allude to moral education. It is to be remembered that a bodily infirmity is not the only thing to be corrected. The habit of drunkenness is a disease of the mind. The soul itself has received impressions that are incompatible with its reasoning powers. The subject, in all respects, requires great address; and you must beware how you inveigh against the propensity, for the cravings of appetite for the poisonous draught are to the intemperate as much the inclinations of nature, for the time, as a draught of cold water to a traveler panting with thirst in the desert."

Withdrawal symptoms of alcohol are more severe than the withdrawal symptoms of morphine. These facts were proved by Dr. Isbell's experiments at the Addiction Research Center at Lexington, Ky. Delirium tremens and convulsions are serious symptoms of withdrawal, and, untreated, result in death in from 5-15% of

* Part 2 of a paper presented before the annual meeting of the Indiana Academy of General Practice, March 16, 1961, Indianapolis. Part 1 appeared on pages 1142-44, August, 1961, *Journal*. Certain subject matter has been deleted from this material by the author for reasons obvious to those present.

the cases. Many of these alcoholic deaths occur in our general hospitals in patients who have been admitted for other reasons and alcoholism is not known to exist.

General attitudes of the profession and the laity alike continued to be that "Alcoholics were weak-willed, self-pampered, spineless drunks, who were digging their own graves, and should be permitted to continue doing so undisturbed."

Treatment of the Patient

History of the alcoholic pattern is essential . . . the extent of his drinking pattern and prior treatment in rest homes, private treatment centers, and hospitals . . . how he has reacted to withdrawal in the past, may be very important to his future management. If he states that he does fairly well for 3-4 days and then has convulsive seizures and blackouts, you had better believe him and manage him with this in mind. Frequently we see a man who is not in too bad a shape, but who—after 24 hours of abstinence—becomes a raving madman.

The patient usually presents himself when "he's hurtin'." He has physical symptoms of his drinking — shakes, tremors, sweats, dry heaves, etc. He may be in your office to get your signature on an insurance blank because of absence from work, or for nothing more than to get his wife off his back by pretending that he is seeking to do something about his drinking. Regardless of his reason for being in the office, he—at this time—may be more vulnerable to the pin-pointing of his problem because—at this particular time—he knows he is in trouble. I prefer the patient to make his own appointment at my office after the routine patients are taken care of, and not sandwiched in with other patients. The reason for this is certainly clear to you.

Should Include Mate

The husband or wife should accompany the patient, for in this way both understand what is said, what the problem is, and what has to be done about it. The patient is given a chance to read and answer diagnostic questions and arrive at the diagnosis of his situation . . . along with the diagnostician. In the usual typical case the patient breaks out in a grin when he is asked: "Where do you hide your liquor?" I do not ask him IF he hides his liquor, because I know that if his wife is pouring out his supply—or is continually nagging about his drinking—he will begin

to sneak drinks and hide his supply. He will have adjusted his pattern of drinking to allow him to continue his drinking as long as he can. He will only drink after 6 p.m.; only drink beer; only drink at home;—even *not* drink for a week—a month—or a year—to try to prove that he can handle the problem. He has promised his family time after time that he will quit drinking—only to find himself drunk within 24 hours.

The alcoholic has no use for the individuals whom he can con concerning his situation. Even though, when you confront him with your impression, he may become very belligerent—he will, nevertheless, respect you for your frankness and understanding. For underneath his belligerent attitude he knows you are right, even though he will not admit it.

I usually tell him that medical care to improve his well-being so that he can get drunk over and over again is not my intent, but if he wants to do something about his drinking, I'll help him all I can. If he wishes to drink himself to death it will be his problem. I'll lose no sleep over it. This is nothing more than placing the responsibility in his hands—for anyone can sober up an alcoholic, but the alcoholic who wants to is the only one who can stay sober.

The severe alcoholic who has had D.T.'s or convulsions should be hospitalized. Others, less severe, may be placed on medication controlled by some member of his family. The alcoholic will take medication the same way he drank—to oblivion, if possible. Never give an alcoholic any more medication than you want him to take all at once.

I will not go into details of medications which might be given to correct the disturbed physiology. Treatment of the withdrawal symptoms is clearly outlined in the various medical texts. Prior to any medication, Alcoholics Anonymous is mentioned as the best specific help for this disease (and it is well for you to be acquainted with this fellowship in your communities). If it is possible, allow this man to make a contact with a member of AA before giving him medication or allowing him to leave the office. If he is allowed to get over his sickness before making contact, he may never do it, and you may never see him again.

Medication

I might mention what I use in office patients—in the way of medication. Usually: (1) Sparine

tab. 25 mg—12 in number—with directions of one every 4-6 hours as needed for nervousness; (2) Elixir of Benadryl, ounces three, to be taken . . . one ounce at bedtime (his sloe gin on retiring); and (3) Tuinal, gr 1½—4-6 in number with directions one or two at bedtime for sleep. These medications are given to the relative and are to be dispensed by them—with “no refill” on the prescription.

Now, since we are dealing with an addict, it is important that sedative relief of his anxieties by medication should not be continued in the average case longer than 5-10 days, because of the fact, as mentioned by Lovell & Tintara in 1948: “It is as essential for an alcoholic to refrain from sedation as it is to refrain from drinking.” The alcoholic knows that the simplest solution is to quit drinking, because he has done it thousands of times; and he knows that the toughest thing is to try to play with it as a social drinker. It is well to point out to him that each drinking episode gets worse, and that it takes less and less to give him trouble. There was a time when he received, or seemed to receive, enjoyment out of drinking. But now he finds nothing but misery—mental and physical.

The Therapeutic Team

It is well to establish a therapeutic team for this patient; you—as his physician, a contact

with AA, a clergyman of his faith, an attorney, an employer (Personnel Man or Medical Director), and a representative of any other areas where his problems have become obvious.

This statement I believe: “An alcoholic should never be treated in a penal, mental, or religious institution” . . . but as a particular entity. His institutionalization should not *just* be domiciliary care, but educational—to give him insight as to the medical, physiological, psychological, psychiatric and spiritual nature of his illness . . . hence frequently the facilities are referred to as “The College.”

Alcoholics Anonymous has had by far the most outstanding success in the solution of the problem of the alcoholic. Why? Take a look at the program of Alcoholic Anonymous, considering the twelve steps of that program.

We must accept the challenge before us concerning this public health problem, and perhaps we, as a profession, in our time may be able to pass on to the oncoming generations some evidence of our contributions to the solution of this problem . . . each in our own way. ◀

817 Chamber of Commerce Bldg.,
Indianapolis

The Case Of The Durable Kitten

I was called to see little Rosemary who was said to have a very bad cold. I found her lying on the couch. I sat on the “matching” chair at her side. Both pieces of furniture were much worn with the loose coil springs easily outlined against their covering of some dark material. When I sat down I thought the chair seat seemed a little lumpy but blamed it on the springs prodding me.

I cannot estimate how long I was so seated. I took her temp. and pulse in a leisurely manner, also checked her breathing and throat and patella reflex. As I finally got up Rosemary cried, “Oh mamma he’s killed my kitten.” That kitten did really look flattened. Needless to say I was much embarrassed by this event; however, kitty shrugged it off and trotted from the room after a plaintive mew.

H. H.

Clinico-Pathological Conference

Ball Memorial Hospital
Muncie, Indiana
May 2, 1961

Case Presentation

A 29-YEAR-OLD WHITE female gave birth to her first child, a normal 8½ lb. living boy. She was known to be Rh negative (cde/cde), and her blood group O. Her husband's blood was grouped and typed as A Rh positive (CDE/c-e). During her second pregnancy, four years later when she was 33, her physician again noted that she was Rh negative. Laboratory tests showed a gradually rising titer of Rh antibodies and blocking antibodies, as follows:

	4-23-60	9-16-60	9-22-60	9-30-60
Hemantigen	neg.	pos.	pos.	pos.
Anti Rh ₁ (CDe)				
saline agglutinins	---	128	512	512
Anti Rh ₂ (cDE)				
saline agglutinins	---	256	128	512
Anti Rh ₁ blocking antibodies	---	256	neg.	neg.
Anti Rh ₂ blocking antibodies	---	1024	1024	neg.

These antibody titers showed no further increase a week later. She had a 20-pound weight gain during the pregnancy as well as normal urinalyses and blood pressure.

Three weeks prior to the expected termination of the pregnancy a Caesarean section was performed and a viable male infant was delivered. Physical examination revealed a pale seven pound boy with a spleen palpable two fingerbreadths below the costal margin and liver palpable three fingerbreadths below the costal margin. The infant had grunting respirations.

The infant's hemoglobin was 9.0 gms, and his hematocrit was 26%, with a total nucleated cell count of 18,060, but a corrected count showed only 6,820 to be leukocytes, the remainder presumably normoblasts. The differential count was 3 eosinophils, 67 lymphocytes, 2 monocytes, 1 myelocyte, 1 metamyelocyte, 12 bands and 14 polymorphonuclear leukocytes. The "direct" bilirubin was 0.3 mgm per 100 ml of blood and the "indirect" bilirubin was 2.3 mgm per 100 ml of blood. A direct Coombs test on the baby's blood was positive. The baby's group and Rh type were A, CDe.

An exchange transfusion was performed, although there was some difficulty in cross-matching the donor and recipient blood, and a total of 570 cc of blood was exchanged.

The following day, the hematocrit was 24%, hemoglobin 7.5 gms, with 211 normoblasts per 100 white cells counted and the total "leukocyte" count was 40,630, with 4 eosinophils, 39 lymphocytes, 1 monocyte, 3 myelocytes, 1 metamyelocyte, 30 bands and 22 polys. The "direct" bilirubin was 2.0 mgm per 100 ml of blood, and the "indirect" 9.0 mgm per 100 ml of blood. The infant was taken to the operating room for a second exchange transfusion but he died before the blood could be given.

Discussion

DR. ROBERT GIBSON: I would like to start my discussion at the time of the physical examination. We are confronted here with a 33-

year-old woman in her second pregnancy, the first pregnancy being uneventful. During the second pregnancy it was determined that she was Rh negative and that she was sensitized. Since erythroblastosis fetalis immediately comes to mind as most likely, I shall direct my remarks to this diagnosis.

At birth this infant showed signs of hemolytic disease of the newborn with an enlarged spleen, enlarged liver and grunting respirations. The hemoglobin was 9.0 gms, hematocrit 26%. Other pertinent laboratory findings were: direct bilirubin of 0.3 mgm %, indirect bilirubin 2.3 mgm % and positive direct Coomb's test. The baby's group and type were A,CDe(R₁). A 570 cc exchange transfusion was performed despite difficulty in cross-matching the donor and recipient blood.

The following day, the hematocrit was 24% and the hemoglobin 7.5 gms, with 211 normoblasts. Direct bilirubin was 2.0 mgm per 100 ml of blood and the indirect was 9.0 mgm %. At this time the infant was taken to the operating room for a second exchange transfusion but it died before the blood could be given. Even at this time, the bilirubin was not at a dangerous level. It has been fairly well established that to produce kernicterus the indirect bilirubin must be near 20 mgm %. The one possible exception is in the premature baby, since they sometimes develop kernicterus at lower levels.

You might mention the possibility of this being ABO incompatibility. ABO incompatibilities are usually milder and very rarely cause this much illness in the newborn period. The Coomb's test is often negative also.

Premature Induction Controversial

The decision as to whether or not to interrupt the pregnancy in this woman, who has been shown to be sensitized in her second pregnancy, is controversial. Some observers feel that the first time the mother is sensitized, the chances for a surviving but perhaps sick infant are as good if the pregnancy terminates spontaneously. The physician is not then confronted with a premature baby who may have difficulties other than the erythroblastosis. However, Allen¹ feels that any woman who is sensitized and has a high antibody titer should be considered a candidate for premature induction of labor.

Between 1948 to 1952, it was felt that perhaps the mortality from erythroblastosis might be reduced by terminating the pregnancy before

term. Mollison² and Vaughn *et al.*³ found that instead of reducing the mortality rate, they actually increased the mortality by the early induction of labor. Infants died not only because of prematurity, but they also had a greater incidence of kernicterus. At about this time the exchange transfusion was introduced. However, with the then-usual single exchange transfusion, the rate of kernicterus still was higher in the premature patients.

The situation is a little different now, but there is still some controversy as to the selection of cases for premature induction of labor. If a woman has had one fetus dead of erythroblastosis, the chances for the next Rh positive fetus are as follows: stillbirths 75%, born alive but with extreme anemia 15%, and born alive with readily treatable disease only 10%⁴. In those cases where there have either been previous stillbirths or a severely affected infant, I think that there is universal agreement that premature induction of labor is indicated. The preferred method of induction in these women is medical rather than surgical. Surgical termination of the pregnancy by Caesarean section is indicated only when medical induction fails.

As to management of the infant, it is fairly clear that he was severely affected by hemolytic disease of the newborn. A hemoglobin of 9.0 gms indicates severe involvement. In addition, I believe the baby was in congestive heart failure, although the venous pressure is not recorded. This type of heart failure is called "high out-put failure" with an increased blood volume, as frequently seen in other kinds of anemia. An exchange transfusion was indicated, but special care must be taken with an infant with severe hemolytic disease as well as congestive heart failure. In such instances, the infant may improve dramatically if a deficit in his circulating blood volume of anywhere from 30 to 100 cc is produced. This very often relieves the distress, and the oxygenation of the blood removed from the umbilical vein is seen to improve. After producing such a deficit the routine exchange transfusion may be continued.

With a patent catheter in the umbilical vein the venous pressure should not exceed 10 cm of blood when the baby is quiet. This is readily measured by elevating the catheter and measuring the height of the column of the blood in the catheter. If it exceeds 10 cm, the baby is in congestive failure and this is when one proceeds

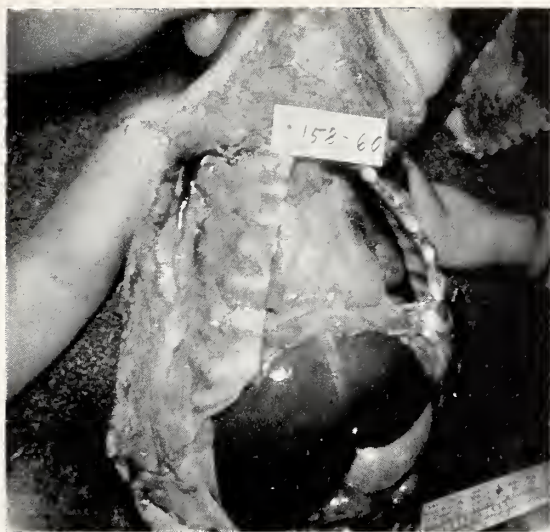


FIGURE 1

MARKED HEPATOMEGALY and partially collapsed lungs. Also note slight increase in transverse pericardial diameter, suggesting cardiac dilatation.

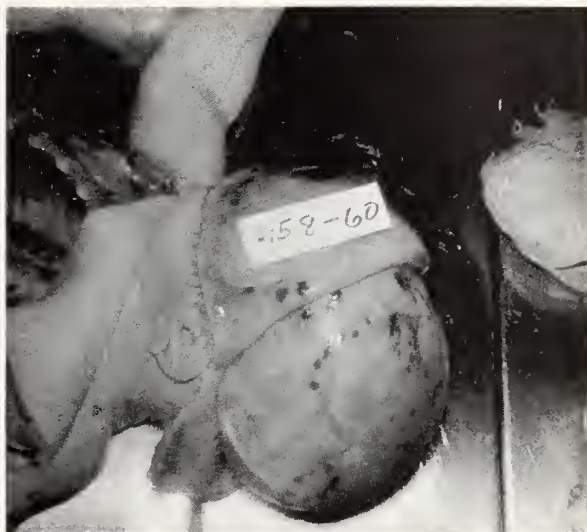


FIGURE 2

HEMORRHAGES on the periosteal surfaces of the skull.

to produce a deficit. We produce the deficit slowly by removing 10 cc of blood at a time until the venous pressure is less than 10 cm. At this point it is sometimes advisable to stop the procedure and let the baby stabilize. "Spun-down" donor's cells, which have less plasma and more cells, may be used to improve the baby's anemia and oxygen-carrying capacity.

Considering Exchange Transfusion

Exchange transfusion should not be considered lightly. Even in the best of hands the mortality rate is somewhere between seven and 10 percent. Boggs *et al.*⁵ had a mortality rate of 7.3% in their series of 519 patients. I am sure in the hands of those less experienced the mortality probably reaches 10 to 15%. Some indications for exchange transfusion are as follows: all infants who are born more than two weeks before term whose red cells give a positive Coomb's test; mature infants whose cord hemoglobin concentration is below 14.0 gms %; infants in the first 24 hours who show an increase in the bilirubin of 10 mgm % per hour; any infant whose cord bilirubin exceeds 5.0 mgm %; and an indirect serum bilirubin approaching 20 mgm % regardless of cause.

The exchange transfusion should have been performed here not only to alleviate the baby's distress, but also to improve the congestive failure. It would be unnecessary to attempt a volume exchange to reduce the serum bilirubin. The bili-

rubin at this point was not near the dangerous level, and actually was probably within normal limits for cord blood. At a later time when the baby was perhaps in a better condition, the procedure of a routine exchange transfusion could have been performed.

Everyone who is concerned with this problem should familiarize himself with all possible aspects of treatment. Each case has its own peculiarities and the decision to exchange the baby depends somewhat on your own experience as well as the experience of others. There is an excellent review by Vaughn⁶ of this whole problem from the detection of the Rh negative woman through the handling of the infant.

I believe this baby died of hemolytic disease of the newborn, due to an Rh incompatibility, and that the cause of death was congestive heart failure.

Pathologic Diagnoses Discussed

DR. ROBERT CHRISTIE: Pathologic diagnoses included erythroblastosis fetalis, as Dr. Gibson suspected. The lungs were atelectatic, partially due to the fact that the intra-abdominal contents were increased in volume. It may be seen (Figure 1) that there was marked hepatomegaly and partially collapsed lungs. There was also slight increase in the transverse pericardial diameter, suggesting cardiac dilatation. Figure 2 shows hemorrhages on the periosteal surfaces of the skull, and section of the brain

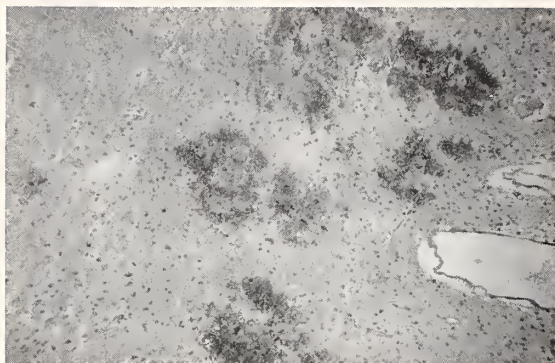


FIGURE 3

SECTION of the brain showing small perivascular hemorrhages.

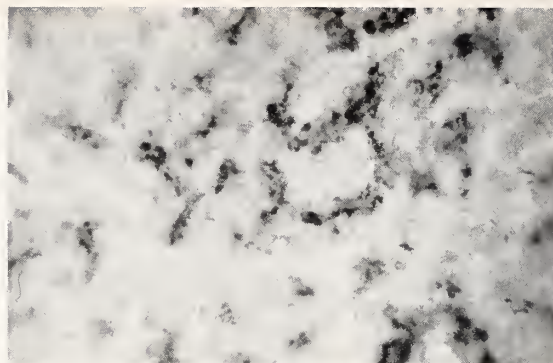


FIGURE 4

IRON DEPOSITION of the liver shown by iron stain.

(Figure 3) showed small perivascular hemorrhages. Microscopically, there was extramedullary hematopoiesis in the liver, spleen, lungs and testes. There was iron deposition in the liver shown by iron stain (Figure 4) and there was also iron pigment in the renal tubules, all highly suggestive evidence of an intravascular hemolytic process.

The clinical differential diagnosis in this case included erythroblastosis due to Rh sensitization and ABO sensitization. I think the antibody studies show fairly well the fact that there was specific Rh sensitization. The fact that the Coomb's test was strongly positive is good evidence that this is an Rh rather than an ABO problem. The Coomb's test may be positive in the ABO incompatibilities but it is not usually as strongly positive and in very many cases it is negative. This is one of the diagnostic landmarks in differentiating the two diseases. Furthermore, the history of an Rh negative mother, with Rh positive husband, who has trouble during her second pregnancy would certainly arouse one's suspicions of an Rh sensitization. Very often, as you know, the ABO incompatibilities manifest themselves in the first pregnancy. Rh sensitivities never do unless there is a history of prior blood transfusion.

The peripheral blood smear from infants with Rh incompatibility shows macrocytic erythrocytes. Infants with ABO incompatibility, on the other hand, have spherocytes.⁷

One of the laboratory tests used in screening the serum of women who come for antenatal antibody studies is the "Hemantigen" test. This is a trade name for a commercial product which consists of a conglomeration of erythrocytes

which will demonstrate any "immune," "cold" or "saline" antibodies. It will not react with natural anti-A or anti-B. If the test is positive, then the patient's serum is further screened for immune antibodies. If these are found, they are titered, so that the degree of sensitization may be evaluated before the baby is born. Generally speaking, the higher the agglutinating and blocking antibody titer, the more apt the infant is to have trouble.

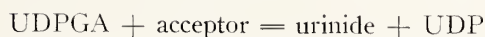
Change in Antibody Titers

One of the more interesting phenomena that takes place during the pregnancy of a sensitized woman is the change in the antibody titers. For some reason if the blocking antibodies rise to a high level, the child may be expected to have severe problems at birth. Also, if the blocking antibody titer rises above 64, one can usually expect the infant to have hemolytic disease of the newborn. You will note that the infant here had a titer of 1024. These blocking antibodies will pass the placental barrier⁸ but the agglutinating antibodies will not. The agglutinating, but not the blocking, antibodies tend to persist from previous pregnancies if sensitization has taken place. Just what happens to the blocking antibodies at or near term is uncertain but perhaps they pass the placental barrier and are then absorbed or "soaked up" by the infant's erythrocytes and tissues. They often disappear in the latter weeks of pregnancy, and if they do the infant's prognosis is usually poor. The agglutinating antibodies ("saline agglutinins") tend to stay at about the same titer during the last weeks of pregnancy, and rarely is there an increase or decrease in the saline agglutinin titer after the 35th week. This brings me to the point of dis-

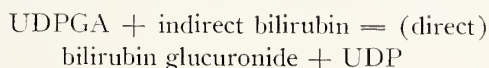
cussing the problem Dr. Gibson raised about early induction of labor and Caesarean section at or after the 35th week of pregnancy.

It is generally conceded that there is no advantage whatsoever of doing a Caesarean section because erythroblastosis is imminent. The reasons for not performing a section are based on the known patho-physiology of the premature erythroblastotic infant. To fully appreciate this we have to consider briefly the biochemistry of bilirubin.⁹

Direct bilirubin contains glucuronic acid, while bilirubin of the indirect type (resulting from erythrocyte breakdown) lacks glucuronic acid. Indirect bilirubin must be changed in the liver by conjugation with glucuronic acid before excretion as direct bilirubin through the bile ducts can take place. The synthesis of urinides, to which glucuronic acid is related, is dependent on two enzymes in the liver, one a coenzyme which is heat stable and the other a heat labile enzyme. The coenzyme is uridine diphospho-glucuronic acid (UDPGA). The reaction may be expressed as:



In the case of bilirubin metabolism, the reaction involving this coenzyme UDPGA is as follows:



This reaction is of considerable importance in the formation of indirect bilirubin resulting from the hemolysis of erythrocytes, and it is catalyzed by transferase. Transferase (not to be confused with transferrin, which has to do with iron metabolism), is relatively low in the liver of the newborn, and particularly the premature infant. This very likely explains the high frequency of jaundice in the premature infant.

It is suspected that kernicterus results from an excess of indirect bilirubin which exists at very much higher levels in premature infants with erythroblastosis fetalis. It has been shown also that the brain contains a lipid which takes up indirect bilirubin, but not direct bilirubin.¹⁰ Thus kernicterus is directly related to prematurity. Clinically, it is more frequently seen in the premature than in the full-term infant. So any decision which involves delivering a premature erythroblastotic infant can be criticized on the grounds that an infant is obtained who is al-

ready severely anemic and who has been shown to handle indirect bilirubin poorly. The stress of being delivered to the external environment of course undoubtedly increases the infant's metabolism, and this too likely results in hemolysis of more cells. The excess indirect bilirubin produced can not be excreted in a satisfactory manner, and kernicterus may be the fruit of the surgeon's labor.

Caesareans Noted for Respiratory Problems

If you will recall, at autopsy we found that this infant had atelectasis of the lungs. We see this so often at autopsy in infants delivered by Caesarean section that I believe this point should not be taken lightly. Infants delivered by Caesarean section apparently don't have the benefit of having their thoracic contents thoroughly squeezed out, if we can use that phrase to describe what happens when the baby travels through the birth canal. Caesarean section babies are notorious for the respiratory problems in the early neonatal period. Almost all authorities now are agreed that premature induction of labor by Caesarean section is not desirable in the treatment of erythroblastosis and Caesarean section is to be condemned unless there is cephalo-pelvic disproportion, placenta praevia, or some other special reason which of itself will justify this method of delivery.

It must be remembered that fetal hemoglobin is present in high proportion at the time of birth in all infants. As far as I know there is no evidence of preferential destruction of fetal hemoglobin in hemolytic disease.¹¹ However, the bilirubin derived from fetal hemoglobin might differ from that derived from adult hemoglobin. The implications of this on the development of kernicterus are unknown and remain a theoretical moot question.

The laboratory had the problem of selecting proper blood for the exchange transfusion. For some reason an attempt was made to cross-match donor blood with the infant's blood rather than following the recommended procedure of cross-matching donor blood with the mother's blood. The rationale is that if the maternal serum does not hemolyze the donor cells, the infant's serum also will not. It is well to remember that what we want is *cells* which will survive in the infant until the infant can produce its own unsensitized cells.

We always use Rh negative group specific donor blood. For a time there was a belief that you could give Rh positive cells and these would tend to "soak-up" the antibodies which were circulating in the baby's blood, but controlled studies revealed that statistically there was a higher mortality when Rh positive blood was used.

In an infant not too severely afflicted with disease, one exchange transfusion of properly selected blood will probably suffice for several months, with the hemoglobin remaining above 8 or 9 gms per 100 ml.¹²

DR. GERT VOSS: Dr. Christie, was fresh blood used in this exchange transfusion?

DR. ROBERT CHRISTIE: Yes. We try to use fresh blood whenever we can and we are reluctant ever to use blood older than five days. In an extreme emergency, of course, older blood than that can be used but for the reasons that older blood tends to hemolyze and that the potassium content of the serum tends to go up in stored blood, we prefer to use blood less than 24 hours old. We can not always meet this ideal criterion.

I might mention that the question of whether citrate in the amount that is given to the infant in an exchange transfusion is apt to have any severe effect on calcium metabolism is a pertinent one, and I think that 1 ml of calcium gluconate per 100 cc of exchange blood is usually an accepted amount. Obviously, this can't be injected into the donor blood since it will result in the blood clotting. It has to be given independently and very slowly, because a large volume of calcium given rapidly to a small infant can be disastrous. How do you feel about this Dr. Gibson?

DR. ROBERT GIBSON: We routinely use calcium gluconate in the amount you mentioned, and quite often we detect a very dramatic change in the infant's behavior after giving the calcium. Prior to the calcium the babies are irritable, they are kicking, they are very fussy and almost immediately after you give the calcium they quiet down. Whether or not this irritability is due to low calcium, I don't know, but every time you give the calcium one can see that there is a very marked change in the baby's behavior.

Amount of Blood Exchanged

DR. KEITH HAMMOND: Doctor Gibson, since you are just exchanging blood, it seems ob-

vious that the total amount of blood exchanged at any one time is not terribly important, but would you mention the amount of blood usually given in a single exchange?

DR. ROBERT GIBSON: I don't think I can give you a rule of thumb on that. If the infant is in good condition, we ordinarily give 500 cc and we sometimes exceed that in an infant who is in no distress. I think that most people feel that 500 cc is adequate. Generally speaking, using the volume of blood equal to the infant's circulatory volume would be sufficient.

DR. ROBERT CHRISTIE: Doctor Gibson how would you handle the blood volume problem in an infant with congestive heart failure?

DR. ROBERT GIBSON: If you had a severely affected infant, such as this infant, I would think you would certainly want to clamp the cord as soon as possible after delivery and you certainly wouldn't want to milk the cord, nor would you want the cord to pulsate for long because the baby is already hampered by an increased blood volume and this would tend to lead to heart failure. This brings up the point that there is a tendency to figure at the end of the procedure that because the baby is anemic it will help to "top off" the transfusion by giving 40 or 50 extra cc of blood. Here you are really flirting with danger because the baby is potentially in a decompensated state and adding 40 or 50 cc of extra blood volume, which in a baby is a considerable portion of its total blood volume, is extremely dangerous. I think most physicians with experience in administering exchange transfusions produce a deficit of perhaps 20 to 30 cc of blood at the start of the transfusion and then proceed to exchange the baby from this point, volume for volume. It is certainly better to have a deficit than a surplus of blood when there is any possibility of heart failure. Did you have any other comments, Dr. Christie?

DR. ROBERT CHRISTIE: Mollison¹² says that infants with hemolytic disease tend to die in one of three stages:

First, they may die within 12 to 24 hours due to cardiac failure secondary to prolonged anoxemia. Simple transfusion of these infants is dangerous and often leads to circulatory overload and death.

Second, they can die within 36 to 96 hours, and these infants often have deep jaundice and

kernicterus. If exchange transfusion is carried out soon after birth, the majority of the infant's sensitized erythrocytes are removed. This is important when it is realized that in an infant with 6 gms of hemoglobin per 100 ml, 500 mgm of bilirubin would accumulate in two or three days, presuming that each gram of hemoglobin is converted to 40 mgm of bilirubin, and that in severe cases of hemolytic disease, the infant's erythrocytes life span may be as short as two to three days. From the practical point of view, relatively little bilirubin is removed at each exchange of 300 ml. However, in an exchange transfusion, most of the infant's erythrocytes are removed and replaced by Rh negative erythrocytes, which are not subject to the rapid destruction that Rh positive erythrocytes are.

Third, they may die from seven to 21 days after birth. These deaths, which are due to profound anemia, are no longer common since the disease is frequently diagnosed at birth and quickly treated. Severe anemia occurring after the first seven days can be treated by simple transfusion.

The infant discussed tonight had severe erythroblastosis, with severe anemia and heart failure, and unfortunately had been delivered by Caesarean section. I am afraid this represents an almost unbeatable combination of circumstances.

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Surgery in General Practice

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AS A GENERAL PRACTITIONER, my entire career has been devoted to both the practice of medicine and general surgery. I shall attempt to discuss surgery as it pertains to the G.P. I would like to talk about several facets of both minor and major surgery, as they are performed both in the office and in the hospital.

Due to our positions as family doctors, we are usually the first to see the myriad of traumatic injuries that may befall the average family: lacerations, contusions and abrasions, some of which are minor and some major in degree. Many times we are judged by the manner in which we handle these injuries.

Undoubtedly, the mechanical injury which results in lacerations and contusions of the body, especially of the head and hands, is the most prevalent injury which we commonly see. There are three cardinal factors in the repair of wounds of this type:

(1) Control of loss of blood; (2) protection of the patient against bacterial invasion and (3) repair of the wound so as to minimize any cosmetic or mechanical defect. In wounds of the scalp, it is most important that the hair about the wound be shaved so as to give the operator a clear view of the wound to be repaired. If he will then inject the open edges of the wound with a product that I have found to be extremely useful, that is 2% novocaine with the addition of 1-20,000 Suprarenin solution, usually gross bleeding will stop.

If you do not attempt to expose or cleanse the wound until anesthesia is present, the patient will be more cooperative and you will be able to do a much better job. It is always very important that a thorough inspection of the

wound be made for foreign material, which when found, needs removal. All the rough edges and devitalized tissue of the wound should be excised with a sharp scissors. Tincture of green soap and sterile water make a very excellent cleansing agent, and in large wounds, vigorous use of a scrub brush is an excellent method of cleaning out foreign material. If there is grease in or around the wound, it can be easily removed by the use of benzene or ether.

After thoroughly cleansing and debriding the wound, I frequently flood the area with hydrogen peroxide.

Tincture of merthiolate, or your favorite antiseptic solution may then be applied prior to suturing with OO dermal suture on a cutting edged needle. Using interrupted sutures, incorporating the entire thickness of the scalp, you will find that it is seldom necessary to ligate minor blood vessels. Any major bleeders should be ligated with OOO plain catgut and the ends cut short. Use of dressings on scalp wounds has never seemed to me to be of any great importance. I advise the patient to practice ordinary cleanliness and perhaps apply a little tincture of merthiolate daily. In extensive head wounds, where there has been separation of the scalp from the skull, a pressure dressing, maintained by an ace bandage, will minimize formation of a hematoma. All patients should receive 1500 units of TAT or 1/2 cc tetanus toxoid as a prophylactic agent against tetanus.

Hand Injuries

Some of our most severe injuries occur in the hand, especially the fingers. In crushing injuries to the hand, particularly in which machine tools have been the agent of trauma, it is imperative that an x-ray be taken prior to proceeding with any repair work to the extremity. Many times

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you will find a fracture or a foreign body which you did not see or suspect. The x-ray will also serve as a legal record of the extent of the injury. Every attempt should be made to refrain from amputating fingers. Unless at least one flexor tendon plus the nerve and blood supply of one side of the finger remains, you will rarely succeed in saving the finger. However, whenever there is any doubt in your mind as to the possibility of saving a finger, I believe you are justified in making that attempt, regardless of the outcome.

One should always carefully inspect the fingers for evidence of severed tendons. It is very easy to miss a severed tendon unless you specifically check to see if the fingers can be put through their full range of motion. Inability to flex the distal phalanx against resistance indicates that the profundus tendon is severed. Injuries to the sublimis tendons result in the inability to clench the fist. If both tendons are cut, the two distal joints remain straight, although the finger can still be flexed at the metacarpal phalangeal joint. As a rule, extensor tendon injuries are fairly obvious and can be easily diagnosed by the failure of the patient to completely extend his fingers.

In repair of flexor tendons, where the tendon may be retracted up into the hand, it is usually advisable to have an assistant, since some of these repairs can be exceptionally difficult and time-consuming. With careful preparation and a deliberate approach, tendons can usually be found. After finding the tendons, both the distal and proximal ends will usually be frayed or contaminated; it is often best to excise a small portion of the ends with a sharp knife. Holding the finger in flexion, so as to relieve tension on the tendons themselves, the tendon should then be approximated by means of fine black silk or a 000 chronic catgut suture. By careful traction on the tendons one can then determine whether or not the finger is functioning properly.

Preventing Infection

There is always danger of infection about these tendons, which can destroy your work; therefore, one should be very meticulous about removing all devitalized tissue and foreign materials. Adhesions about the tendons at the site of suture are very common and many times result in malfunction of the finger.

If at all possible, one should suture a small

layer of fatty tissue over the suture line, which will offer the least resistance to any adhesions that might be formed. The skin wound can then be closed by means of interrupted dermal sutures, a copious dressing applied, and the finger splinted in flexion by means of a posterior splint which may be either of metal or plaster. This splint needs to remain for at least 3 weeks. Its early removal may result in separation of the tendons at their suture line with a consequent loss in function. It is usually best to dress these fingers about every three to four days and to be on a careful lookout for any pus that might form along the suture line. If any stitch shows evidence of inflammation, it should be removed immediately. These patients should all receive large doses of antibiotics, especially penicillin, and of course tetanus antitoxin or toxoid.

Repair of Extensor Tendons

Repair of extensor tendons usually poses no unusual problem. These tendons should be identified and sutured in the same manner as flexor tendons, excepting that the fingers should be splinted in extension using a splint, either metal or plaster, on the flexor surface of the hand and forearm. This splint also should remain for a period of approximately three weeks. There is usually very little loss of function in most injuries to the extensor tendons of the fingers. Occasionally you will have a hand wound which will require extensive repair, perhaps beyond your ability, and if help is not readily available, one should feel free to cleanse and debride the injury just as you would in any severe wound and if at all possible to tag the tendons for future identification. The skin should be closed in the usual manner and large doses of penicillin should be given; after a period of 30 days the secondary repair can be done under more ideal conditions.

Preventing Carcinoma in Females

As family doctors, we have the responsibility of safe guarding our patients from cancer. We can be of inestimable value to our patients by doing frequent pelvic examinations, especially on those women who complain of vaginal discharge. Sometimes this discharge may be described as bloody or purulent, or merely mucoid in nature. It is very easy to give these patients some type of medication without doing a thorough pelvic examination, but one should not fail to examine them completely. Examination

may reveal a cervical polyp, cystic disease, chronic endocervicitis, or perhaps a cervical erosion. Hospitalization is advised, and under anesthesia, any suspicious or pre-cancerous lesion should be biopsied. If the biopsy is benign, the cervix should be coned by means of the diathermy knife.

If the patient is still in the childbearing age and is desirous of having more children, it is probably better to do a radial coagulation of the cervix, followed by fulguration of the cystic areas that may be present. However, if this patient is not in the childbearing age or does not desire more children, a thorough conization should be done.

Personally, I have never seen a patient develop carcinoma of the cervix, at any time in her life, when she has had a thorough conization of her cervix. These patients are always grateful for the absence of discharge which follows cervical conization and they get the added protection of prophylaxis from the development of cervical carcinoma.

Any woman who complains of pain or lumps in her breast or axilla should be examined immediately. Every suspicious mass that is obviously not inflammatory in origin, should be excised under general anesthesia and sent to the laboratory for diagnosis. If the lesion is malignant, a radical breast amputation need be done, followed by deep x-ray therapy to chest and axilla. Many times we advise the patient to wait, in order to see what will happen, but this is a questionable procedure, and I doubt if it is ever justified.

Acute Abdominal Problems

Many problems are encountered in diagnosis and treatment of the acute surgical abdomen which we are so frequently called out to see, occasionally in the middle of the night. There is no phase of surgery in which judgement, based on clinical experience, is of greater importance than in the diagnosis and management of acute surgical diseases of the abdomen. One must be sure that he takes a careful history and does a complete physical examination. A routine urine, C.B.C. and specific laboratory tests, applicable to the situation, along with roentgen studies, should enable one to make an accurate diagnosis. If you are unable to make a precise diagnosis immediately, one should at least be able to determine whether or not this is a surgical abdomen,

also if it is an emergency case, or whether it can be watched for some time and a more complete work-up done, followed perhaps by surgery at a later date.

Of course our most common surgical emergency of the abdomen is that of acute appendicitis. Most of us know the symptoms of appendicitis to be that of colicky pain, usually originating in the upper abdomen or about the region of the umbilicus, lasting for several hours and finally migrating down into the right lower quadrant of the abdomen, and localizing beneath McBurney's point. These patients usually are slightly nauseated. Occasionally they will vomit once or twice. They have usually felt that if they could have a bowel movement, their symptoms would be relieved. Many times they have taken a laxative with very little relief from pain. They are usually running a temperature of one degree, rarely more than two degrees. If they are up and about, they walk in a more or less stooped position. They have pain on raising their right leg and the slightest jar results in pain in their abdomen in the region of McBurney's point. Usually a blood count will reveal an elevated white blood count of 12-17,000 wbc's with 75-90% polys.

In elderly or debilitated patients this will not necessarily hold true. Pain increases in intensity as time goes on. The abdomen is usually silent and as a rule there is no history of diarrhea. These patients should be taken to surgery immediately. If it is a man it is best to do a McBurney incision; in women however, I feel that one should do a right paramedian incision in the lower abdomen because there is always the chance that your diagnosis is incorrect and if there is some involvement of the ovary or tube, your incision will facilitate your proceeding with the necessary corrective surgery.

There have been numerous articles written about the method for handling the appendiceal stump. I have found that by doubly ligating the appendiceal stump with a chromic O tie, excising the appendix, cauterizing the stump with phenol and neutralizing the phenol with alcohol, I have never had a complication following this procedure. I do not think it is necessary to purse-string the appendiceal stump or do any elaborate procedure in order to prevent the appendiceal stump from blowing out. All that is required is two secure ligatures about the stump, and in

cutting the ligature ends, I usually let them remain long, approximately $\frac{3}{4}$ of an inch.

In a ruptured appendix it now is not considered too fashionable to drain the right colic gutter, but I still feel that my patients get along better and faster if a small rubber drain is inserted into the right colic gutter and brought out through a stab wound and left in place for a period of two or three days. It is good insurance and I see no reason for not continuing this procedure.

Perforated Ulcer

Sudden excruciating pain in the upper abdomen, with or without a prior history of epigastric distress or the history of an ulcer, associated with a board like rigidity, comprises the usual clinical picture which is found in a perforated ulcer. For some strange reason, many times, the patient will be awakened from his sleep with this sudden attack of pain. These patients are usually brought to the hospital in a relative state of shock. They are begging for relief from their pain, and usually require several injections of morphine before being able to cooperate. They sometimes describe the onset as a feeling of hot fluid running from the epigastrium down into the right lower abdomen. These patients, many times because of stomach distress, have taken some type of alkali—frequently Alka Seltzer prior to retiring. The diagnosis usually can be confirmed by a flat x-ray picture of the abdomen, which will reveal air under the diaphragm.

These patients should be placed on immediate Levine tube drainage for evacuation of the stomach prior to going to surgery. I have always felt that early surgery was the best procedure, and even though at the present time there are some advocates of continuing the patient on medical treatment by continuous Levine suction, I do not go along with this mode of thought, and operate these patients as soon as I have made my diagnosis.

There is a current trend to do a subtotal gastrectomy immediately at the time of perforation of the ulcer; however, I feel that these patients are not in good shape at this time and it is such a simple matter to close the duodenal perforation, that a thorough evacuation by suction of all undigested stomach contents along with any Alka Seltzer, Tums, or soda which has

contaminated the abdominal cavity is the method of choice.

One can do an upper right rectus incision. This incision should be carried fairly high in order to give good exposure of the stomach and duodenum. The majority of these lesions are located on the anterior surface of the duodenum and are readily accessible. After isolating the lesion, it is best to close the perforation by means of two or three interrupted intestinal sutures, and if there is a small mass of omentum present, tie this down over the perforated area. After thoroughly aspirating the abdomen of all foreign material, one should insert a small soft rubber drain into the area of the lesion and bring it out through a stab wound in the right subcostal area, then close the wound carefully in layers.

These patients should be kept on gastric suction for a period of four to five days following their surgery and adequate fluid balance maintained. Following removal of the Levine tube, they should be put on a sippy regime and maintained on this for considerable time. Penicillin and streptomycin given intramuscularly every 12 hours will reduce postoperative complications. The future of these patients is determined by their progress on medical therapy as evaluated by progressive x-ray studies.

Gallbladder Disease

The patient who has a sudden attack of nausea and vomiting, associated with pain in the right upper abdomen which radiates posteriorly beneath the right scapula, should immediately be suspected of having acute gallbladder disease. These patients are usually obese and 40 years of age or over, although this is not necessarily true. I have seen patients who were extremely thin and young who had suffered with gallbladder disease for quite some time before the true nature of the cause was suspected.

In a very severe attack, which starts out with a high white blood count of 20-30,000, one should keep these patients under careful observation because of the possibility of the development of gangrene. This complication, as well as empyema, should be thought of when the temperature rises and the pain continues for a period of 12-24 hours without any diminution in intensity. There is always the possibility of rupture of the gangrenous gallbladder with a resulting bile peritonitis; therefore, the procedure of choice is

a cholecystectomy. If the patient's condition is at all satisfactory, I think one is justified in proceeding with the cholecystectomy and not taking the chance that the pathological process will subside. If there is any possibility that the patient may have a stone in the common duct at time of operation for acute gallbladder, there may be some advantages in preliminary cholecystostomy before exploration of the common duct is attempted. One can do cholangiograms through the cholecystostomy tube later and the presence of stones in the ducts can then be more definitely located and the surgical removal carried out more safely and accurately at a subsequent time, at which time a cholecystectomy is done.

Acute pancreatitis is more properly in the category of an acute non-surgical abdomen in the light of current thought regarding treatment in the initial acute phase. Severe upper abdominal pain, which resembles a perforated ulcer or acute gallbladder disease, may prove to be due to an acute pancreatitis. Fortunately, we have laboratory tests which are of great value in the differential diagnosis of acute pancreatitis from that of other upper abdominal surgical diseases. A routine serum amylase determination will usually show marked elevation and is practically diagnostic of acute pancreatitis. Development of shock in acute pancreatitis is a serious omen and may indicate a fulminating pancreatic necrosis which may not be helped by any therapy.

One should give supportive treatment to these patients; plasma, blood, adequate fluids, antibiotics and Levine suction should be maintained. Following an acute attack of pancreatitis, calcification sometimes develops in the pancreas and these calcified areas can be seen by x-ray. There may develop a large pseudo cyst, which can obstruct the duodenum by pressure or perforate into the free peritoneal cavity. This is one disease that should always be kept in mind when seeing a patient with acute severe upper abdominal pain and especially if there is evidence of shock. It definitely must be differentiated from an acute perforated ulcer.

Intestinal Obstruction Also Common

Intestinal obstruction is another very common cause of severe abdominal pain. In obstruction of the large bowel, one must always keep in mind, and especially is this true of old people, that fecal impaction may give the impression

that the patient has an acute large bowel obstruction due to carcinoma and is in need of a colostomy. Sometimes these impactions are high up in the sigmoid or descending colon and it is with difficulty that this impaction is made to pass, so as to relieve the obstruction. The slow onset of colon tumors has been emphasized many times and probably the earliest symptoms which one can elicit will be those of history of change in bowel habits. This symptom is probably present in 80-90% of all cases. Patients may complain of increasing constipation or of alternating constipation and diarrhea; they usually have cramp-like abdominal pains and there is very seldom any vomiting. Occasionally these patients will pass bright red blood or the bleeding may consist of small streaks in the stool. The finding of occult blood in a stool specimen may be a clue that there is a slow loss of blood from the gastrointestinal tract. Anemia is frequently the only finding in lesions of the colon, especially those on the right side. Due to the liquified fecal stream on the right, obstruction usually occurs late in the development of the obstructing lesion. Most of these patients first complain of weakness and fatigue, which is due to their profound anemia.

Clinical differentiation of diverticulitis and carcinoma of the sigmoid and descending colon may be quite difficult. A barium enema may solve your problem; however, if partial obstruction exists, it will be up to the surgeon to determine whether the lesion is malignant or inflammatory. He often faces a difficult diagnostic problem. If the mass in the sigmoid region involves a considerable segment of bowel and if it is adherent to the surrounding structures, the surgeon may be quite certain that the lesion is an acute diverticulitis. A carcinoma of the sigmoid colon, on the other hand, involves a much shorter segment of the sigmoid colon and is usually free unless it has perforated the bowel wall; in this case it may be adherent to the surrounding structures; however, this usually does not occur unless the lesion is far advanced; sometimes a correct diagnosis will not be definite until the segment of bowel is resected and examined by a pathologist.

Challenge of Small Bowel Obstructions

Obstructions of the small bowel present some of the most challenging problems in surgical diagnosis. Although the x-ray may show a char-

acteristic pattern of small bowel distention which is practically diagnostic, there are numerous instances in which the x-ray diagnosis will not be definite. Serial x-rays of the abdomen taken every 48 hours may show some significant distention of a loop of bowel and thus provide a more reliable clue in your diagnosis. There is nothing, however, that will substitute for a good history. Because you hear episodes of increased peristalsis, simultaneously with cramp-like pains, this may be of little help to you, for this is also common in severe gastroenteritis, which is a non-surgical entity.

Just because the patient continues to pass some feces and some gas, with or without an enema, you should not assume that obstruction is thereby excluded. Many times there is enough fecal material in the colon that with an incomplete obstruction, a small amount of gas will pass along with some feces. This may lull you into a false sense of security. I do not think that one should depend too much, for treatment, on intestinal intubation with the Miller-Abbott tube, because many times, while you are decompressing the small bowel an area of gangrenous bowel may perforate.

These patients require the most careful observation. Their fluid balance should be maintained and if they do not make marked improvement in a very short period of time, they should be operated on as surgical emergencies. Many of the obstructions in the small bowel are due to adhesions which develop as a result of a previous surgical procedure. Any patient that has had one or more surgical attacks on the abdomen should be suspected of a small bowel obstruction.

These are the easiest of operations from the standpoint of surgical procedure. Many times, only the snipping of a small adhesion will release the obstruction and the closing of the abdomen completes the operation. Occasionally we may have a small bowel obstruction due to benign, adenomatous polyps which are found in the ileum. The resulting intussusception, sometimes which may be precipitated by an attack of diarrhea, can be reduced manually.

Another common cause of small bowel obstruction, probably the most common, is that of external hernia. Incisional hernia are quite obvious and usually easy to diagnose. Frequently, these can be reduced by manual compression. The inguinal hernia is probably the most common site of strangulation, and due to its easy access-

ability, usually presents no diagnostic or surgical problem. Femoral hernia, however, can easily be overlooked as a cause of pain, due to small bowel obstruction. The little lump which you might find in the groin may not be drawn to the attention of the doctor, and you will be preoccupied with the abdominal symptoms and overlook this part of the examination. In operating for a femoral hernia, the approach from above the inguinal ligament is the most desirable. It is much easier to repair the opening in the femoral canal more satisfactorily, so as to prevent recurrence. Meckel's diverticulum with perforation is quite uncommon, but it must always be remembered. The diverticulum is usually located within 2-3 feet of the ileo-cecal valve. Occasionally it will be found to be actually inflamed and should be resected.

Where the etiological factor is obscure, and you feel sure that you are dealing with a small bowel obstruction, upon opening the abdomen you may be confronted with a thrombosis of the mesenteric vessels. Here a wide resection is mandatory, in order to insure adequate circulation to the anastomosis.

Intussusception in Children

In children, one must be cognizant of an intussusception. A six-months-old child, never having had a sick day in his life, who suddenly screams out with severe pain, vomits once or twice and becomes pale and limp, should immediately be suspected of having an intussusception. Usually these babies will pass a small amount of blood with a thin stool. They resist examination of the abdomen because of the intense pain, but with careful examination one can usually palpate a large mass in the right upper quadrant or in the region of the transverse colon.

Usually the diagnosis is confirmed by giving the child a barium enema. Occasionally, this will reduce the intussusception, but one should not depend on this or use excessive force in order to reduce the intussusception. Immediate operation is in order and usually, if one will take his time and be patient, the intussusception can be reduced. It is rarely necessary to do an intestinal resection if diagnosis is made relatively early.

Female Abdominal Illnesses

There are three, more or less, acute surgical abdominal illnesses common to the female sex, that may require emergency surgery. The most common of which we formerly saw, but thanks

to the antibiotics we seldom see today, is that of pelvic inflammatory disease. This ailment frequently simulates appendicitis so closely that surgical intervention may be necessary in order to rule out acute appendicitis. However, a careful history of perhaps a purulent discharge, menorrhagia or metorrhagia in a young female, frequency of urination with some dysuria, pain on defecation and acute tenderness of the adnexa, especially pain resulting from movement of the uterus during the course of a bimanual examination, makes one exceedingly suspicious of an acute inflammatory process in the pelvis.

This disease has now been relegated to that of a medical problem and should be operated only after reaching a state of chronicity, such as the development of a hydrosalpinx or chronic oophoritis, with cyst formation. In women in the childbearing age, gynecological consultation is most advisable before any attack is made on the female pelvis where there is the slightest question of diagnosis.

A ruptured tubal pregnancy is an acute emergency. These patients usually give a history of missing a period. They have been doing some spotting. They often have pain in the lower abdomen, sometimes more on the right, or to the left of the midline. If seen early, these patients will have a positive Friedman test and bimanual examination will reveal a mass either in the right or left tubal area and will be acutely tender. If rupture occurs, blood extravasates into the peritoneal cavity and the patient experiences severe abdominal pain which becomes generalized. Patients develop shock of varying degree, depending upon the rapidity and the amount of blood which is lost into the peritoneal cavity.

This is an acute surgical abdomen and requires immediate blood replacement prior to the emergency surgery. The abdomen has a doughy feeling and a bimanual examination reveals a bulging in the posterior cul-de-sac of the vagina. These patients are in a marked degree of shock and require immediate attention. Upon opening the abdomen, it will usually be full of blood clots. These should be removed as rapidly as possible and the bleeding points in the ruptured tube must be quickly located and clamped. The necrotic tissue which usually is composed of the tube may then be excised in the prescribed manner. The abdomen is closed without drainage and supportive therapy given.

Occasionally a woman who is complaining of severe pain in either the right or left lower abdominal quadrant, may be suffering from an ovarian cyst twisted on its pedicle. Most of the time, these patients can be diagnosed by an adequate bimanual examination and palpating the large mass which is present and which is acutely tender. These patients may or may not have an elevated white count; they may be temperature-free in the beginning. This condition is readily relieved by doing a lower midline abdominal incision, delivering the ovarian cyst into the wound and amputating the pedicle at its base.

Several medical problems can produce acute abdominal pain and should be kept in mind. The early pneumonia which has not produced characteristic, physical or x-ray findings and the coronary occlusion which has not yet produced its characteristic changes in the E.K.G. are diseases which at times can simulate acute surgical diseases of the abdomen.

Herpes zoster in its prevesicle stage, many times will produce pain in the region of the abdomen. Careful examination will demonstrate the pain to be cutaneous in depth and limited in distribution.

Severe gastroenteritis is a very common cause of abdominal pain and diagnosis prior to the onset of diarrhea may be confusing. Auscultation of hyperactive bowel sounds should alert you to the fact that this may be an acute enteritis.

In the diagnosis and treatment of the acute abdomen one must take a broad view of the patient, take a careful history, weigh the symptoms judiciously, and do a complete physical examination. One must use all of our auxiliary diagnostic aids, such as x-ray and the laboratory to the fullest extent. Above all keep your patient under constant observation until you have arrived at a definite diagnosis. In any event when the diagnosis is not clear, and this will be true many times, you should not hesitate to call in a surgical consultant.

An acute abdomen is a constant challenge to all of us. The field of general surgery and general practice is vast and will require you to make a constant study of the wide ramifications of the subjects, in order that you may constantly improve your diagnostic and operative skill. ◀

15 W. Franklin St.,
Evansville



The Case of the Old Man Who Died Young

ARNOLD LIEBERMAN, M.D.

New York, N. Y.

IN MARCH OF 1881, Czar Alexander II, liberator of the Russian serfs, was assassinated by a group of his grateful subjects. That year, many utterly blameless, newborn, female babies (my mother among them) were named Sophia to honor Sophia Perovskaya, leader of the successful plot which many still consider a landmark in the development of the Russian Revolution.

This has absolutely nothing to do with our tale except that Jakie Levy was bar mitzvah that same summer. He had to be 13 to be confirmed; by simple subtraction, we arrive at 1868 as the year of his birth. The place was Kalicz, a little city within the Polish ghetto. Being exactly on the Prussian border, this was the place where passengers going either way had to change trains, as the Russian trains had to go

on broader gauge while the Germans persisted in the more narrow, western gauge. In those days, customs was not the ordeal it was to become after the World Wars; still, passengers did not take kindly to being routed from their comfortable compartments just because they were about to enter another country. Kalicz had a sort of unpleasant connotation to people who had had the misfortune to pass through there in the middle of the night. To others it was just another spot on the map.

The Jewish community was utterly too sunk into its benighted torpor to know or care about the reputation their little ghetto had; it was on a par with the other ghetto communities of the time: anyone reading *Scholem Aleichem* can get a fair idea of its life. Today, this Jewish life is gone: the cataclysms of the 20th century, includ-



ing visitations of Hitler's hordes, have seen to that.

At the time, Kalicz* had the usual synagogue, which formed the hub around which the life of the hamlet revolved. The Levy family was among the poorest but it was proud of Jakele, the leading scholar in the Talmud Torah, the synagogue cheder, i.e., the parochial school for Bible study. Chaim Levy, the village tinsmith, Jakie's father, would speak with great pride of his son being a veritable "Gemorah Kopf"—a scholar steeped in Old Testament lore. Even the

Wooden Synagogues: Maria and Kazimierz Piechotka; published by Arkady—Warsaw, Poland, English version 1959, 293 illustrations and a colored map.

On page 10 of this excellent volume there is a detailed plan of the city of Kalisz as it existed in 1875. It shows clearly the Jewish Quarter around the Horse Market, the location of the synagogue, the town square and the inevitable castle. In the text on the same page there is the statement that, "The Kalisz Charter (Privilegium) granted to Jews by Boleslaus the Pious in 1264 was the cornerstone for further privileges which shaped the conditions of Jewish Life in Poland".

Further in the text, there is the interesting statement that, "Lwow and Kalisz had Jewish settlements *before* the towns were incorporated."

By the turn of the 20th century—some 600 years later—this unique history of Kalisz having been the very first Jewish settlement in Poland was an item totally forgotten.

learned rabbi, wrapped in his long, black, Chassidic robes, would stroke his beard and sideburns, the "payse," and reflectively acknowledge that he had never had a more apt student.

In this remote back-water of Jewish life, the bar mitzvah of such a brilliant student was an event fully as important as the news of the death of Alexander II. Of course, the bitter storms of anti-Semitic programs of the succeeding years were still to come. The vast wave of Jewish emigration from the Polish ghetto to Manhattan's lower East Side was quite imminent but not yet. All this, so far, simply gives us the date when Jakele was born in Kalicz and the fact that its inhabitants had been proud of that boys' coming of age in their community.

Leaves in Haste

Just three years later, Jakele left Kalicz in haste, in the middle of the night and very much under a cloud; in fact, he was lucky to be able to make a getaway over a back path (that he knew well) straight across the poorly-guarded frontier into a safe haven in Germany. The exact circumstances are beclouded by time and by the fact that we have little more than Jake Levy's unsupported recital of the tale. He did not leave because the Czar's officers were desirous of drafting him into the army; he was still only 16 years old. Neither did he leave because pogromshchiks, anti-Semitic hooligans, thirsted for his blood. Nor did he commit any of the usual crimes that make a midnight flight a dire necessity. Not at all: At the very beginning, let us state a most astonishing fact. This adolescent stripling was a male possessed of a masculinity that even Casanova in his prime would have envied!

After making all due allowances for pardonable exaggerations, it seems that some *four* fathers of despoiled daughters and *three* cuckolded husbands had banded together and decided to deal drastically with this precocious darling of the opposite sex! One of these ravished—and ravishing—maidens had overheard the hubbub raised by the gathered men; she had made post-haste to warn her beloved Jake Levy. Quickly, the youth gathered his few worldly belongings and made good his escape across the border. As told to me some 50 years later, Jake had found the time to make passionate love to the fair maiden who had warned him. In others, I would have dismissed this as mere

braggadocio; with Jake, I remained skeptical but not altogether unconvinced.

In any case, Jake Levy left behind a reputation for Biblical scholarship and a blazing memory for that certain something not to be named in mixed company but still to be discussed for many long succeeding years. He traveled through Germany, took an emigrant boat and arrived in New York. He was just another immigrant helping to change the appearance of Hester Street on the lower east side of Manhattan. He was young, healthy, quite intelligent, already an excellent tinsmith, very active in the synagogue he joined—and a man of parts!

Into Trouble Again

He found employment first with an uncle who had come from Kalicz just a year or two previously. He worked, slept and ate in the little basement which was shop and living quarters for a teeming family. The streets of New York were fabulous adventure; the ferry ride to Staten Island an occasional Sunday excursion; the wooded Central Park an ever fascinating forest. Jake Levy attained maturity, developed—and got into trouble yet again!

He had married very early; he had started a family; he was highly respected in the congregation he had joined—still, there was that roaming eye, that Lothario glance, that irresistible charm and uncontrollable attraction to the opposite sex: New York even before the turn of the century was a large city, but Jake Levy lived in what was actually a rather small, tightly knit community; his gadding about with other women was certainly not “kosher” behavior; the young man found it wise to move for the usual, unmentionable reasons.

In Pittsburgh, he did well and even prospered in a modest way. His wife bore him many children. In later years, he did not deny that he continued having amatory adventures on the side. With the passage of years, his tales may have been elaborated and embellished—still, they had an authentic ring. Be all that as it may, Jake Levy did very well after the outbreak of the First World War. He heard from the husband of one of his paramours that there was a fine business opportunity in the burgeoning Calumet district across the Indiana line just south of Chicago.

Jake Levy was glad to shake the complications of Pittsburgh maidens and make a fresh start

in the junk business so near Chicago. His dilapidated wagon with the spavined, sway-backed ancient mare clopping down the alleys of our little town was a familiar sight to me and the other youngsters going to grammar school. When I first knew him, he was already “Old Jake,” although he must have been still in his forties. He would sit on the wagon holding the reins loosely and raising the familiar chant, “Old iron, rags, paper, junk!”

The nag! the misused harness! The open cart with the creaking, iron-rimmed, cock-eyed wheels! The weird assortment of oddments piled on high on the springless vehicle! “Old Jake” guiding the plodding steed forward and making the frequent stops for picking up this and that: A track athlete could envy him the nimbleness and agility with which he would leap down; a weight lifter could emulate the grace and deftness with which he toted the formidable weights and hefted them up on top of the piled-up junk.

The eyes were bright and flashing; the smile was pleasant; the voice was almost melodious. The hair was in long curls but abundant even if already streaked with grey. The nose was rather beaked, projecting prominently over a couple of luxuriant moustaches covering thick, sensuous lips. The teeth would flash dazzlingly every time he parted the mouth—which was often. True, the clothes were old and, of necessity, dirty and not very presentable. The shoes were always in need of a shine although, on the whole, “Old Jake” was far more clean and pleasant than any of the peddlers around town with whom my playmates and I were acquainted.

Some of my more religious Jewish friends would regale us with tales of what Jake did at the synagogue services: apparently his Talmudic lore stood him in good stead. Come Friday, Erev Shabbos, he would bathe, clean up and prepare ritually for the entire Sabbath eve service. In the synagogue, his counsel was sought on weighty matters involving Biblical interpretation. Only the rabbi himself carried more weight with the congregation than did the old junk dealer, Jake Levy. Of course, there were certain ribald tales told by my older compeers, but that is another story.

Feeling Poorly

The years slipped by: it was summer of 1929 and I was a young doctor with a nice new shingle, starting a career in my home town. Jake Levy was among my very first patients. As usual

with him, he was direct and to the point. He had been "feeling poorly," had had "black stools" and had started to lose weight. For a couple months he had been going to one of our venerable practitioners, a graduate of Vienna, vintage 1882. No laboratory work of any sort had been done. The physical examination had been most superficial and the prescribed medicines had not appeared to do any good. Jake had heard of me as "being up on things;" he wanted my opinion as to his condition, "straight from the shoulder."

The old reprobate—now in his early sixties—looked as healthy and muscular as usual. He was erect and energetic; his voice boomed as loudly as ever; his moustaches bristled as fiercely as usual, even if they were grey. His pants did hang a trifle loose on him and the abdomen showed folds of fat apron remnants. There was a vague mass in the cecal region. The liver was palpable at least two fingers below the costal margin and, I thought, there was a definite nodule to be outlined in its edge. The stools were tarry and there was an indubitable secondary anemia present. A barium enema was done the next day by an excellent older colleague. The filling defect was demonstrated easily and it boded no good.

The bad news was given to the patient as tactfully as I knew how. Immediate hospitalization and an exploratory laparotomy were urged. The old fellow neither blanched nor flinched. "You know, doc! Ever since my wife died and my children married, I've been living alone in a house I've bought. . . ." He mentioned an address I knew well by reputation. The place was actually notorious; within the decade, the madam of this house was to acquire national fame of a sort as the red-head who "fingered" John Dillinger for the FBI.

Jake Levy noted the look on my face. "Oh, yes! Annie Sage is a good tenant and her girls are just fine. The police are friends of mine; they get their presents and don't bother the place."

"Thanks for giving it to me straight. I'll have a rousing party tonight and go to the hospital tomorrow!"

And that is how it was. I asked one of my older colleagues to scrub with me. My suspicions proved only too well-founded. There was a large constricting adenocarcinoma involving the base of the cecum. Two large metastases were seen in the liver. Not even a palliative resection was

considered. A biopsy was taken from the primary growth; a snip was also removed from the metastasis occupying the very edge of the liver. Both frozen sections and more permanent slides were made. The hospital had them on file for many years. There could be no question about the nature of this growth. It was about a grade two neoplasm; quite invasive even if somewhat scirrhus in character. The liver nodule was—beyond the shadow of a doubt—more of the same. In view of later developments, these facts assumed an importance not apparent at the time.

Jake was closed up and sent back to his room. He recovered quickly; after all, not much more than a laparotomy had been performed. I never was much of a diplomat and my Cook County Hospital training had not enhanced the finesse of whatever tact I did possess. To his blunt query, "How long have I got, doc?" I blurted out, "Maybe, three months; with luck—six!"

Ruminatingly, Jake Levy looked me over while quoting something from the Talmud to the effect about the Lord's will being done. There was no fear or hesitation in his manner as he made some decisions.

Last Fling

"You know, doc! I've been in this here stock market for some time now and I've made a pile of dough (Remember, this was the summer of 1929). I own a lot of real estate: all clear, too. I'll sell my stocks, take the money and go to California and Hawaii for just one hell of a last spree while I'm still able. After all, I have no obligations to anyone for anything!" He saw the look on my face: "Yeah! I know you are prissy about wenching but me—I play things by ear as God meant me to do."

He quoted the Bible and Talmud at length and to no good purpose even if ever so persuasively—after all, he was a past master at dialectics. Within several days, he was out of the hospital. Within the week, he was off on his safari. I got paid exceedingly well for having done nothing. Also, I received post cards—ribald and pornographic—from California, Hawaii, the Far East, India: apparently, Jake was having one memorable hallelujah of a continuous binge. . . .

The months went by. Much to my growing astonishment, I continued getting cards from Jake Levy!! His vigor and zest for life, i.e., a certain aspect of life, did not seem to diminish.

Next spring—almost a whole year postoperatively—who should stroll into my office but my “doomed” patient. Ruddy, hale and hearty and with yarns to spin. Scenery as seen from bedrooms around the world! And he razed me on my medical prognosis most unmercifully, “You smart doctors! Burying a guy while still alive.” Just looking at him, I could not agree with him more.

Then, he went off on another tack, “But still, young man. Your advice was wonderful, money-wise. I sold at the top of the market and look at it now. Here, doc! Take a C and give your girl friend something.” What could one do with the fellow?

Periodically, as I would see Jake Levy gadding about town, I re-examined the slides of the sections taken at the time of the exploratory laparotomy. Indubitably, they showed a rather nasty adenocarcinoma. Just as indubitably, Jake Levy appeared to be joining that rare, select band in whom a proven malignant neoplasm had regressed spontaneously. Why? How? That is the nubbin of the riddle of cancer. Had I the answer I would be a most famous Nobel prize laureate. But then—as my grandfather used to say—“If potatoes grew in your ears, you’d be not you but a garden. . . .”

Gonorrhea at 72

Tritely enough, the years slid by and World War II was being fought in Europe. In 1940, I spent the summer in part training at Fort Benjamin Harrison. The games were real and they were earnest; Hitler was over-running Europe and we all expected to be in the midst of things right soon. Back home in my office, almost the first patient to greet me was—you guessed it—Jake Levy; he was a very vigorous 72. And what was his problem? An acute gonorrheal infection. It was a bit amazing.

“Jake! I know that you have a ‘housekeeper;’ I am aware of the fact that you visit the girls in that house you own; but—this? Can’t you be more careful?”

The old satyr was almost abashed, “Well, doc! That little clerk in the store was real nice to me last week. How was I to know she was not clean?” This last was asked in the most aggrieved manner possible. To think that he, Jake Levy, at his age should have been hoodwinked by a mere sprig of a strumpet?

“You know, doc! Ever since I’ve been a boy,



I’ve been with a wench at least twice a day—and never any trouble—and now, this.”

The air of self-righteous indignation on the part of the lecherous gourmand furnished a welcome, comic relief to the anxieties of the day. The sensualist patient was treated in the most up-to-date manner with the recently introduced sulfonamides; he recovered without any complications. A very careful roentgenological re-survey of his gastro-intestinal tract revealed no remaining trace of the cancer that had been proven more than a decade previously.

Ordinary Rules Didn’t Apply

Jake Levy continued with his sexual athletics but, somehow or other, the town became tolerant of his activities. The people of our little community looked at him with a mixture of such sensations as astonishment, ribaldry—almost admiration and envy. In his advancing years, his known talents acquired so fabulous an aura that he was established as a town character. He was endowed beyond all ordinary norms: whether from God as he claimed or from the Lord of the Nether Regions—he was blessed (or cursed) and ordinary rules of conduct simply did not apply to him.

Many more years went by; the shooting wars were fought and won for the nonce. I had moved away from the home town; Jake Levy was mostly an anecdotal recollection. The sixties were beginning; it was New Year of ’61. Jake Levy’s career came to a blazing climax—a fitting capstone to a 92-year-old tale. My gossip pal from

the street on which I formerly resided wrote about it in some detail.

It seems that the connoisseur on female pulchritude had spent the early part of New Year's Eve at his grandson's home. Then, he had moved on and called on the gals at the house he still owned. Toulouse Lautrec could not have enjoyed himself more. The liquor was a bit heady and Jake staggered out into the street for a bit of fresh air. At 4:00 a.m. of January 1, he started to cross a street diagonally and against the light. The taxi just could not

stop in time for the lurching pedestrian; Jake Levy never knew what struck him.

A careful autopsy failed to show a single remnant of the cancer that was supposed to have doomed him a full three decades before. The old man had died most youthfully. Incredible? Yes. True? Of course. Is there some moral here? Why be stuffy? The solemn funeral was impeccably orthodox; the glowing memory is outlasting his forgotten contemporaries. ◀

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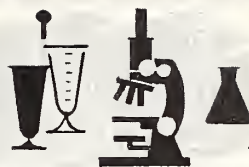
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**INDIANA STATE
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October 24-26

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These dates are somewhat in conflict with meeting dates of the Indiana State Teachers Association. All members are urged to make hotel reservations early in order to avoid a shortage of hotel space.



Forensic Pathology—A Public Necessity

STATUTORY AUTHORIZATION of coroner inquests, one of the most ancient of English common laws, is lost in antiquity. It is known, however, that the coroner's office was originally a Saxon institution and was adopted later by the Normans after their conquest of England. This system was brought to America by English colonists, and persists to this day in Indiana as well as other sovereign states. The term "coroner" derives from the original Latin title *custos placitorum coronal* or "guardian of the crown." By the 14th century the term had been corrupted to "coroner," and the coroner had become one of the foremost of the monarch's legal officers. After Magna Carta the coroner's office lost much of its power and essentially the coroner's task was reduced to investigating deaths occurring under unusual or suspicious circumstances.¹

The coroner was still of considerable importance to the king, however, because he was charged with the responsibility of augmenting the Royal treasury by seizure of contraband and property of murderers and suicides. The coroner was also responsible for the seizure of deodands which, according to Webster, is "property instrumental in a person's death and subject to forfeiture and to be used for some pious purpose." It has been said that as late as 1838 a coroner's jury was able to levy a deodand forfeiture of a considerable sum of money on the boiler of a steamship which exploded and caused human deaths. The forfeitures were generally given to a church for the good of the spirit of the persons deceased, and it is this legal principle and sequence of conviction and indemnification which is the beginning of our present system of industrial compensation.¹

The coroner's office has so changed in the last thousand years that the services of the patholo-

gist are now virtually indispensable to the administration of justice. Unfortunately, a study made a few years ago of the coroner's system of a nearby state, which does not even require the coroner to be a physician, showed that men holding the office of coroner included music dealers, candy makers, farmers, and other persons of diversified talents, and, sometimes, questionable occupations. The most common holder of the office of coroner was the mortician, who often ran for office because as coroner he had access to privileged information, early contact with the families of the deceased and jurisdiction over the body, thereby giving him a competitive advantage over others in his business. Because of such situations, the office of the coroner has lost much of its dignity and influence,^{1, 5} partly due to the absence of any statutory requirement that persons aspiring to the office have special knowledge.

In 37 states any citizen may be elected coroner; in four states justices of the peace function as coroners; three states specify that anyone who acts on order of the court or the prosecuting attorney may be coroner. Doctors of medicine are the medicolegal investigators in nine states and in three states the medicolegal officer is a medical examiner. In some counties, by what appears to be local option, the coroner must be a doctor of medicine despite absence of the statewide requirement.³

AMA Points Out Ineffectiveness

Some years ago the American Medical Association, after conducting a special investigation of the procedure, administration and accomplishments of the current medicolegal systems of the states reached the conclusion that "throughout most of our United States legal medicine is used less effectively in the administration of justice than in any comparable country in the world."¹

To the question of what the basic jurisdictions of the office of coroner should be, the following five suggestions have been made: "(1) Cases of homicide arising from criminality, which includes first and second degree murder, manslaughter, arson, rape, mayhem, abortion, culpable negligence, and death in suspicious circumstances. (2) Cases of suicide. (3) Cases where there is financial association and relevance such as an industrial accident, life insurance claims or other liabilities wherein death has a monetary value. (4) Cases comprising deaths due to the products of civilization, such as traffic accidents, deaths due to noxious gases, industrial solvents, food poisoning, vaccines, serums, pesticides and others. (5) Cases of deaths which, although apparently of natural causes, are sudden and about which there is inadequate clinical data."³

It has been estimated that approximately half of all court cases or damage accidents involve medical testimony or require expert medical survey of the evidence on which legal decisions will be based. What contributions are being made by the pathologists to meet the needs of the present-day coroner's office?

Rapid Recent Growth

Forensic pathology has been developing administrative, educational and research methods rapidly to cope with medicolegal problems.⁴ In the last five years forensic pathology has established itself as an important subspecialty in the field of pathology and there is now the committee on Forensic Pathology in the American College of Pathologists. The American Society of Clinical Pathologists has a Council on Forensic Pathology which is dedicated to the continuing education of pathologists in this field. A Registry of Forensic Pathology at the Armed Forces Institute of Pathology has been established, which is a repository for cases of medicolegal nature and provides a pool of material on which research on unsolved problems may be conducted.

The National Municipal League has campaigned for better medicolegal statutes. The National Safety Committee and its Alcohol Test Committee have been helpful in getting chemical tests legislation passed in 28 states relevant to investigation of the cause of automobile accidents.

Forensic pathology research has been broad and deep. It has directed its activities in such diversified fields as organic phosphate toxicity,

thallium poisoning, alcohol adaptation and tolerance, barbiturate addiction, investigation of unusual poisonous agents (such as jelly-fish and piscines which are capable of causing painful and fatal wounds to swimmers), fatal poisonings from eating liver of blow fish, and identification of sex by studying the nucleus of leukocytes and the sex chromatin in fetal tissues. Establishment of the anaphylactic cause of death from penicillin sensitization is a relatively recent major milestone of medicolegal and forensic pathological research. Pathologic studies of lungs now allows the differentiation of such disease conditions as the Hamman-Rich syndrome, "silo-fillers" disease and "farmer's lung." The medicolegal implications of these diseases are well known and require the expert opinion of pathologists to differentiate amongst them.

Other areas of activity have been the basis for important public safety programs. The recent rash of aircraft accidents has forefronted the recommendations of forensic pathologists on redesign of supersonic airplanes for Air Force and commercial transport operation.

It has become apparent that the most dramatic and apparently the most newsworthy of the coroner's cases such as homicide, suicide, manslaughter and mayhem are no longer the prime circumstances of importance within the medicolegal pattern. Compensation court awards, workman's compensation laws, and industrial accident commissions have given the findings of the medicolegal officers a real and substantial pecuniary value, with far-reaching social values. For instance, they may "determine whether a widow must abandon her maternal status and go to work and support a family after the death of her husband, or whether by an industrial insurance award she may stay home to care for and educate her family. Verdicts can be instrumental in deciding whether children go to college or to day labor, whether a mortgage is foreclosed on the family home, or whether a patient gets private medical care or hospitalization in a publicly supported institution. Thus from an economic point of view the apprehension of murder, the revelation of abortion, or malpractice are less important than the accurate evaluation of the role of effort in inducing coronary thrombosis and heart failure, or the importance of silicosis developed during employment contributing to death from active pulmonary tuberculosis."²

Accidents, particularly industrial accidents, rather than crime, are probably now considerably more important from a medicolegal point of view in our society.

Indiana has failed to employ forensic pathology at a state level to safeguard the public interest.^{5, 6} Since part of the pathologist's training is in methods and technics of forensic pathology, he should be called upon far more frequently than he is in the investigation of deaths in the coroner's jurisdiction. Ideally, coroners' offices should be filled by competent medical examiners, and preferably pathologists with training in forensic pathology. Indeed, the Indiana coroner's law requires that only a pathologist may perform an autopsy on a coroner's case. Continuing efforts to codify the law pertaining to coroners and the coroner system, establishing forensic-science service at a state level and encouraging pathologists to run for the office of coroner are

necessary steps in protecting the interests of the public. Perhaps ultimately Indiana will choose to establish the medical examiner system, a system which has already become a necessity because of the increasing importance of expert opinion in medicolegal problems.

Robert W. Christie, M. D.
Ball Memorial Hospital
Muncie

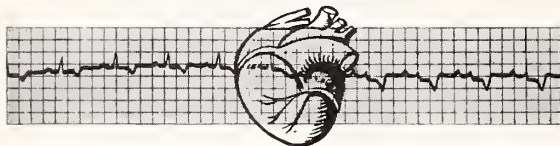
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New Pathology Forum

The Pathology Information Committee of the Indiana Association of Pathologists will conduct a "question and answer" column in the Pathfinder section of The Journal. Queries in the fields of anatomic or clinical pathology may be addressed to The Journal, 1019 Hume Mansur Bldg., Indianapolis 4. Answers and discussions will be published periodically.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Atrial Flutter with Complete Heart Block

*CHARLES FISCH, M.D.**

Indianapolis

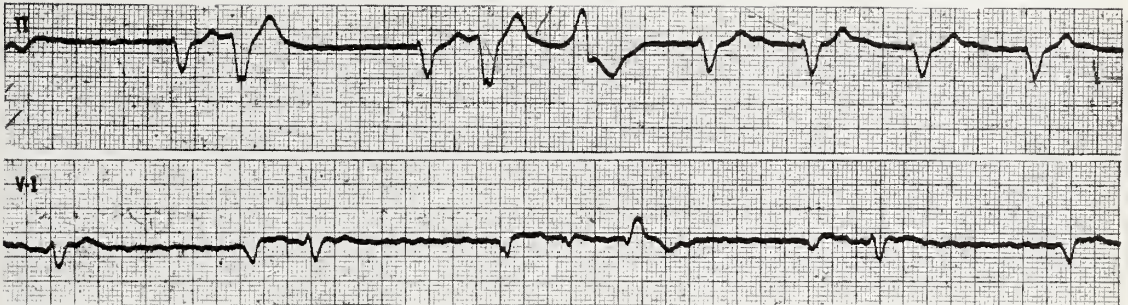
THE combination of atrial flutter and complete heart block is rather uncommon. Review of our files disclosed one case in over 15,000 electrocardiograms taken during the past four years. The patient was a 65-year-old man with congestive heart failure due to atherosclerotic heart disease. The tracing taken on 3-14-55 shows atrial fibrillation and ectopic ventricular beats. The QRS complexes exhibited left bundle

branch block. This was confirmed by a 12-lead tracing not shown here. The patient was given digitalis and on 3-22-55, the tracing shows the classical saw tooth appearance of atrial flutter. The characteristics of complete heart block, namely a slow and perfectly regular ventricular rhythm and lack of any relation of the flutter wave to the succeeding QRS, are clearly demonstrated in V-1. The flutter wave to the QRS distance (F-R), if measured from beginning of the F wave to the R of the succeeding QRS, measure .20, .24, .26, .32, .12 seconds respectively. Such a variation in atrio-ventricular conduction indicates that the F waves are not responsible for the ventricular response.

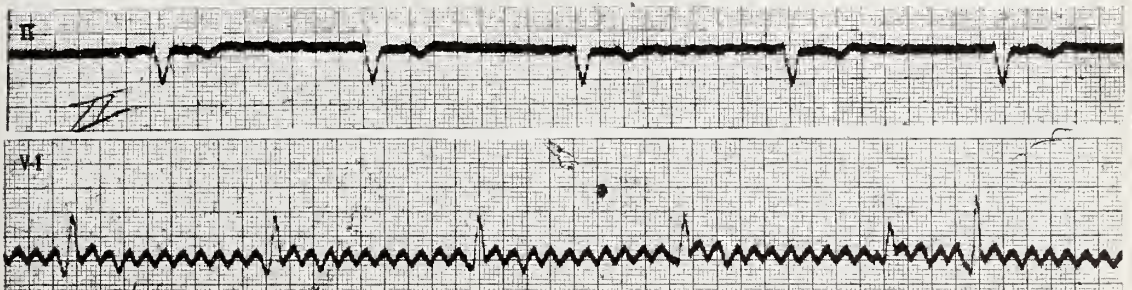
*From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, and the National Heart Institute (H.T.S. 5363).

G.S. 329704
3-14-55



3-22-55



The tracing taken on 3-14-55 shows atrial fibrillation and one recorded on 3-22-55 atrial flutter with complete atrio-ventricular dissociation.

Devoted to the interests of the medical profession of Indiana

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112th Annual Convention

NEXT MONTH an outstanding scientific program combined with sports events, entertainment, technical and scientific exhibits and administrative work will make up the 112th Annual Convention, running for four days, Monday through Thursday, Oct. 23, 24, 25, and 26, in Indianapolis.

On Monday morning the golf tournament drives off at 8:30. At 10:00 the latest addition in sports events, the bowling tournament will get under way for members and their wives. At 11:00 the customary trap and skeet shoot will blast off and at 2:00 the bowling tournament resumes, following a break for lunch.

Also on Monday the Executive Committee, The Council and the House of Delegates will hold their initial sessions in order to avoid interference with the splendid scientific sessions on later days.

The scientific program is based on the principle of studying a few conditions at a time and studying them well. The program committee has chosen two common clinical conditions, hypertension and surgical diseases of the gastro-

intestinal tract. Both of these subjects will be presented from the standpoint of diagnosis and medical and surgical treatment.

Hypertension will be considered in relation to diagnosis on Tuesday morning and in regard to treatment on Tuesday afternoon, both times by the symposium and panel technic. Drs. Hickam and Judson of Indiana University School of Medicine will be joined by authorities from Cleveland, Houston, Columbus, Ohio, Boston and Durham for the latest sound advice on hypertension.

Wednesday afternoon will be devoted to a panel discussion of surgical diseases of the gastrointestinal tract, with Dr. Ken Warren of Boston as moderator and Drs. Hazard, Pugh, Noer and Shumacker as participants.

Thursday will be set aside for section meetings in the morning and the final meeting of the House of Delegates in the afternoon.

Numerous fraternity, specialty associations and honorary societies are sponsoring luncheons and dinners. This year the many medical specialty and sub-specialty societies of the state have

been invited to meet during the state convention. Most of these groups will be meeting either with their respective sections or not.

The entire scientific program is approved for

Category II credit, and the Instructional Courses for Category I credit by the Indiana Academy of General Practice. All times appearing on the detailed program are Eastern Standard.

National Fund, AMEF Are Firm Support

THE NATIONAL FUND for Medical Education receives contributions from business and industry just as the American Medical Education Foundation receives contributions from physicians. Both have the same purpose: to aid medical schools.

The National Fund, with S. Sloan Colt as president, reported its best year in 1960. Contributions reached a new high and were in excess of \$2.4 million. Aided by a matching grant from the Ford Foundation, the National Fund was enabled to distribute \$3,138,460.00 to the country's 85 medical schools. This represented an increase of \$100,000 over the grants made in 1959.

Over 1900 corporations participated with gifts ranging from \$5.00 to \$100,000. Individuals also contributed to the Fund's Teaching Budget Program to the amount of \$23,219.

Grants to Indiana University School of Medicine were for \$50,100 in 1959 and \$51,000 in 1960. Most of the payments to medical schools are in the form of Teaching Budget Grants which are calculated on a formula of \$15,000 per year for four-year schools, \$7,500 per year

for two-year schools, and in each case \$60 per year for each undergraduate student.

Special grants from the National Fund are made under the Developmental and Special Purpose Program, or under the Medical Research Program. These two programs are new and in the experimental stage. Both are operating on relatively small budgets with the expectation of expansion if experience indicates the advisability of such action.

The National Fund was organized in 1949 under the leadership of Dwight D. Eisenhower, then president of Columbia University; Herbert Hoover, and Dr. James B. Conant, S. Sloan Colt and other educators and business leaders. Mr. Colt has been active in the Fund since its inception and is now its president.

Both the National Fund and the American Medical Education Foundation have prospered and their grants have risen slowly and steadily. Each fund has increased the number of contributors year by year. Medical education in the United States has benefited, not only by the financial aid, but by the enlistment of a host of friends in the business and industrial world.

About Medical Students*

THE PRACTICE of medicine, as a career, is apparently losing its appeal to our most brilliant and capable young men and women. This unfortunate situation has not yet received the publicity it deserves. The situation is serious, for the future of American medicine can be no better than the collective ability of those who are now seeking to enter the profession.

According to the AMA Council on Medical Education, the nation's medical schools in 1950 accepted only 28.8% of those who applied for admission. In 1959, in order to fill their classes,

it was necessary for them to accept 53.6% of those who applied.

Furthermore, in 1950, 43% were A students, 40%, B, and 17%, C. In 1958, the A students were only 16%, while 70% were B and 14% were C. Of the 8,173 students enrolled in all first-year medical school classes in 1959-60, 637 withdrew or were dismissed. Of this number, 401 were eliminated for academic failure.

It is apparent that changes have taken place, which have made a medical career much less attractive than it used to be. Some of the reasons may be among the following:

1. Medicine's "bad press." There has been much propaganda about the profession's

* Reprinted with permission from *Western Medical Journal*, Vol. II, No. 5, May, 1961.

"changed attitude." The picture of the bearded family doctor sitting by the bedside of the sick child in the humble cottage has been posted everywhere, especially by doctors themselves. The people contrast this old scene with the efficient modern physician with his business-like office and impersonal hospital to the latter's detriment. No one explains that the old boy probably lost the patient who could easily have been saved by present day technics. This is only another example of the maudlin and harmful "public relations" of which we have been the victims.

2. In recent years, much publicity has been given to engineering as a vocation. Modern airplanes, electronics, rocketry and construction offer vast opportunities.

3. The large salaries, bonuses and stock issues offered to corporation executives dwarf the income possibilities in medicine, especially since doctors seldom have the income tax advantages available to corporation executives.

4. The long, expensive period of preparation for a medical career as compared to the time required to prepare for other, perhaps more remunerative, careers discourages many. Many a doctor today enters practice at the age of 30, has his coronary at 45 or 50, and is lucky if only mildly disabled thereafter.

5. The growing invasion of private practice by insurance plans and socialized arrangements is removing the greatest incentive to enter the practice of medicine—the satisfaction of forming close personal friendships with a fairly permanent group of private patients without the interference of a third party.

6. Last but not least the growing malpractice racket is a strong deterrent to any thoughtful prospective medical student. Regardless of possible insurance protection, no doctor cares to view each patient as a potential malpractice plaintiff.

It has been suggested that each physician constitute himself a committee of one to interest outstanding youngsters in a medical career. This is excellent, but no one could conscientiously do so, without also pointing out the disadvantages involved.

Our judges, legislators and social workers, as well as the general public, should be made aware of the foregoing facts. No greater disaster could befall us than serious deterioration in the quality of American physicians. And make no mistake. That deterioration will continue while present trends go on unchecked.—Edmund T. Remmen, M.D., *Editor*.

A Clinic to St. Mary's*

THE PURPOSE of this contribution is to bring to the attention of physicians, and perhaps interested laymen, some of the reasons why enlightened doctors are adamant in their opposition to further socialistic federal encroachment on the private practice of medicine.

In Alaska the health of the native population is the responsibility of the Alaska Native Health Service, a branch of the United States Public Health Service. While the latter organization is quoted with great reverence on polio vaccinations, irregularities of the drug trade and other

matters, pertaining to the physical and mental welfare of the American people, I have long suspected that this bureaucratic monument has feet of clay.

Recent cleverly worded articles, particularly in *Look*, keep pushing for the further socialization of medicine. Labor, not quite so tactful, is outspoken in its desire to have the government run the practice of medicine. I ask the editors of all national publications and in particular I ask labor groups to read the following account with an open mind. It is an example of the practice of medicine by government.

Last year at Eastertime, Mr. John Spahn, an optician friend, and I flew to St. Mary's Mission on the lower Yukon to examine the 250 school children from an EENT viewpoint. This mission school was established by the Jesuits to educate

* This significant commentary appeared originally as an editorial in *Northwest Medicine*, June, 1961. It is reprinted by special permission. Dr. Fritz is past-president of the Alaska Medical Association and for many years was delegate from Alaska to the American Medical Association.

intellectually superior Eskimo children. A few students are there because they are orphans or from broken homes. The Order has taken in these children to give them some sort of home and education until a proper niche can be found for them.

On that visit we had bad flying weather all the way and instead of spending five days at the Mission as we had planned, Mr. Spahn and I were only able to work there three days. In that time we examined over 100 children and prescribed 66 pair of eyeglasses. Some of these spectacles were paid for by the Jesuit Fathers themselves, others were provided by New Eyes for the Needy, Inc. of Short Hills, New Jersey. The remainder were furnished to the children by the Eye, Ear, Nose and Throat Foundation of Alaska, Inc.

Among the children examined there were 40 who had irrefutable and clearly visible indications for the removal of tonsils and adenoids. This evidence consisted of six cases with mastoiditis on one side, one patient with bilateral mastoiditis, and the remaining cases with either dry perforations or badly scarred and retracted eardrums.

The 1960 St. Mary's clinic was undertaken at no cost to the government but the results of our findings were forwarded to the Public Health Service Area Medical Director as is our regular practice. Soon after this report was submitted the Father in charge of the Mission received a letter from the Area Medical Director saying that the 40 children recommended for tonsillectomies or tonsillectomies and adenoidectomies would be airlifted for surgery at the nearest satellite hospital operated by the Alaska Native Health Service at Bethel, 100 miles away.

Operations Not Performed

This year Mr. Spahn and I intended visiting St. Mary's Mission again at Easter in order to complete the work we had begun the year before. About three weeks before our planned departure we were appalled at finding that of the 40 children reported as being badly in need of T&A's, only two had been operated upon. Accordingly we wired the Father, asking if he would be interested in having us remove the children's tonsils and adenoids instead of continuing with the general work we had started. He answered immediately that he would be very happy to have this work done as apparently the Alaska Native Health Service was unable or un-

willing to do anything other than what has been indicated above.

With the tireless devotion of my wife, who is my partner in these enterprises, and with the assistance of a fine office staff, it was possible to sterilize and wrap disposable drapes and other materials for the removal of 40 sets of tonsils and adenoids. We placed a rush order for a case of ether and a case of Vinethene and purchased a \$240 suction and pressure machine for administering ether by insufflation and for removal of secretions during surgery. In addition, we shipped twelve sets of tonsil and adenoid instruments from my own office to the mission. All this was undertaken on a rush basis through the good offices of Northern Consolidated Airlines, who gave our medical supplies priority in spite of a backlog of three weeks freight to the Yukon. It was necessary to carry the 45 pound pressure and suction device in my small airplane, which already had a staggering load to carry across the snow covered tundra.

Upon arriving at St. Mary's we were greeted with the usual enthusiasm and warmth which is in such contrast to the lethargic, disinterested greeting one often receives at the U.S.P.H.S. hospital here in Anchorage.

It developed that a lay apostle who is a full-time public health nurse in Colorado was in residence at the Mission for one year giving her time and talent for the glory of God by serving children along the lines of her training. She indicated that there were 20 more individuals who needed their tonsils and adenoids removed and asked if we would undertake it.

We had only five days in which to accomplish all this. Nevertheless, we started to work at once, stopping only to wire back to Anchorage for additional supplies. There was no one to handle anesthesia so I doubled as anesthetist and surgeon for 34 of the cases. Once the child was asleep the insufflation device and the suction-pressure machine were turned on and Mr. Spahn either increased or decreased the amount of ether according to the vital signs upon which I kept an eagle eye while operating.

Three lay sisters assisted me. One reassured the children, another acted as instrument nurse, while the third washed instruments. Some of the larger and stronger boys acted as stretcher bearers and the Reverend Mother Superior was our circulating nurse. The Colorado public health nurse handled the logistics—the difficult task of

administering the hypodermic and intramuscular injections of Thorazine, Demerol and atropine that were ordered before surgery and also the roster and meeting place where physical examinations of the next day's patients would be performed.

Water Supply Critical

Because of permafrost and the surface water situation at this particular time of the year the water supply at the Mission was very critical. We ran out of water on every day except the last one and had to wash our hands under a pitcher of flowing water and then rinse them in alcohol. We ran completely out of clean laundry. Children gave their beds to others from the village and they themselves slept in their sleeping bags on the floor. Postoperative nursing care was provided by a parent (if the child was from the nearby village) or by a volunteer adult. The patients slept overnight in our makeshift infirmary and walked out the following morning as the new day's contingent arrived for their operations. Everyone turned to with a willingness that made it a pleasure and an inspiration to give one's best.

All the patients did well. Three had to be resutured. One had what seemed like an epileptic grand mal seizure in the early period of recovery from the anesthesia. Because the Fathers had made available a tank of oxygen from their welding shop we met this emergency with no difficulty whatsoever.

On Friday, the fifth and last day of the clinic, we found that we had performed 71 operations. Thirty-four tonsils and adenoids had been removed under general anesthesia and the remainder of the tonsils or tonsils and adenoids were removed under local anesthesia. Surely if one otolaryngologist with the help of an able and willing lay crew can perform such a prodigious feat, a government hospital such as the U.S.P.H.S. operates in Anchorage with an annual budget of \$12 million should be able to do at least half as well. It should be able to do it continuously and relentlessly, thereby matching the continuity and relentlessness of suppurative middle ear disease and mastoiditis in Alaska.

Lack of water, lack of a nurse-anesthetist, improper bed space, inadequate nursing personnel—each one of these stumbling blocks would have been sufficient for the Alaska Native Health Service to have cancelled out such an effort. Their philosophy through my experience at least

has been that whenever something can be discovered that prevents a perfect project, the defect, no matter how insignificant, can be blown up and presented as reason enough for cancelling an entire program.

Let anybody who approves of the practice of medicine by the government read and ponder on what has been written here.

The reader may wonder why we suddenly decided to undertake this seemingly impossible task with inadequate facilities and personnel. The reason was pure anger and disgust. It was also felt that if this thing could be brought off successfully, perhaps there would be enough feeling and anger generated among physicians and laymen so that the Public Health Service would be awakened (even if rudely) and their status changed from that of ruling servants to medical servants who actually accomplish what they are being paid for.

Before concluding I would like to present an example of the inefficiency of government medicine as practiced in this part of the country at least. The reader should feel indignant and incensed.

Of the 71 patients operated upon, 14 had been seen in 1949, 1953 and 1959 and had been recommended for the removal of tonsils and adenoids. The faithful and indefatigable public health nurses who made these recommendations and forwarded them to the representatives of the Alaska Department of Health and the Alaska Native Health Service saw their efforts come to nought.

Of these 71 patients, four had actually been in the Alaska Native Health Service Hospital in Anchorage *for other reasons*, but because they had not been brought to the attention of the ENT department, they had returned to the bush country with their tonsils and adenoids uncomfortable in place!

At this point it might occur to the reader that the author of this contribution is middle ear or mastoid happy. Let him search the record and in it he will find that within the past three years mastoiditis and middle ear disease constitute the leading public health problem among the natives of Alaska since tuberculosis in its protean manifestations has been more or less laid low with new medications and surgical technics. Various officials of the Alaska Native Health Service at public medical meetings have acknowledged this to be the case. What has been described above

is the method of medical bureaucracy in attacking this profoundly important problem.

The issue now lies before the public of whether or not it wishes medicine to be practiced by the doctors of its choice or through physicians whom the bureaucrats, in their wisdom, choose

for them. If in the light of this the public chooses federalized medicine, it will indeed get what it deserves.

MILO H. FRITZ, M.D.
1027 Fourth Avenue
Anchorage, Alaska

Editorial Notes . . .

The establishment of prizes for Public Health Achievement, the Bronfman Prizes, has been announced by the American Public Health Association. The awards are furnished by the Samuel Bronfman Foundation. From one to three prizes will be awarded each year. Each prize consists of \$5,000 cash and a commemorative symbol. The awards will be given for work of particular effectiveness in applying newer scientific knowledge to community health. The first awards will be announced this fall in Detroit at the Association's annual meeting.

The money (estimated \$252 million) wasted on quack and useless treatment of arthritis by far exceeds the amount of private funds available for scientific research into the cause of arthritis and its cure.

The College of Medical Evangelists with campuses both at Loma Linda, California and at Los Angeles has changed its name to Loma Linda University. The College has been a medical education center for 56 years under the sponsorship of the Seventh-Day Adventist Church. It is now combined with two liberal arts colleges to form the University.

New note of compulsory retirement, America's biggest public health problem: "In 1948 the University of California's Hastings College of Law, perennially faced with the problem of building a high level faculty, adopted the policy of appointing to its full-time staff only men 65 years of age or over. The Hastings faculty is made up of distinguished scholars and teachers retired by other law schools. It has grown to become the largest law school west of St. Louis, and its graduate body has one of the highest records of achievement in the country." The

quotation is from an editorial in the July 15 issue of the *New York State Journal of Medicine*.

Fire is a terrible thing, and in the presence of the sick and disabled it is even more so. The National Fire Protection Association of Boston, in line with its policy of providing fire-safety information on specialty buildings, has just issued the 36th in a series of bulletins of this nature. It deals with hospitals and in 24 pages covers prevention, safeguarding of patients, confinement of fire, and many special problems peculiar to hospitals. Copies may be obtained from the association for 50 cents.

The search for 1,500,000 unknown victims of diabetes in the United States is being helped by the Public Affairs Committee by means of a newly printed pamphlet and a public information motion picture film. Both the pamphlet and the film are titled *Diabetics Unknown*. Prints of the film may be borrowed for showing at club and society meetings. Copies of the pamphlet may be obtained for 25 cents. Inquiries should be sent to the Committee at 22 E. 38th St., New York, 16.

In 1970 the United States will need 11,000 more doctors than it has today just to maintain the present ratio of doctors to population. This will require more medical schools. The original cost of a medical school is now thirty million, upkeep is two and one-half millions annually. More and more students are requiring scholarships. An increasing number of physicians today are taking a neutral or negative attitude in regard to their sons entering medicine. These not-too-cheerful observations were reported at the recent Annual Clinical Institute of the Michigan State Medical Society.

President's Page

WEST EUROPE, 1961

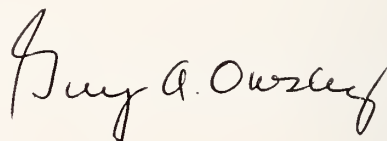
Because I believe that it is desirable for physicians to take vacations, I want to devote this page to our experience while traveling in Europe this summer. We—my wife and I—decided sometime ago that this would be a good year to visit the “old country.” Reference to Europe as the “old country” is hardly appropriate now, but more of that later.

Our reasons for selecting this year were many. First the AMA meeting in New York seemed a desirable time to embark and the International Congress of Otolaryngology in Paris furnished a legitimate medical excuse at the other end. Furthermore my wife had never visited Europe and in my case it was a matter of revisiting to see the changes that have come about. Believe me they are numerous.

In this instance travel was arranged by the Chicago Motor Club through car rental. The car chosen was an Opel Kapitän, a GM product made in Germany, with a standard non-automatic shift. After stalling the motor no less than 20 times we finally accustomed ourselves to what seemed to us an antique mode of transportation. On our way from Rotterdam through the Benelux countries, West Germany, Switzerland, and Italy we completed a somewhat arduous journey by winding up in Paris.

More about the changes that have taken place. For those who are planning as I did to revisit, and in my wife's case a first look, don't expect anything much different than you will find in the good old USA. Supermarkets, motels, bowling alleys, hamburgers, soaring suburban land values, traffic jams, discount houses, television and frozen foods. All of these and more are changing the face of the “old country.”

In short the “affluent society” of Western Europe is making itself known. Even before this is printed, *Time* and *U. S. News and World Report*, have given accounts of the tremendous potential of the amalgamation of the Common Market Countries with the European Economic Community. With this we agree. Never before have so many people devoted themselves to a higher standard of living. The bicycle is giving way to the motorcycle and finally to the automobile and no one can estimate, where the end will be. Yes, the Americanization of Western Europe is nearly complete and the future of their 260,000,000 people combined with ours, will, beyond question, make a world community which will force communism into capitalism.





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The Woman's Auxiliary

REPORTS TO ISMA



Last May, a charter was granted to a newly organized chapter of the Student AMA Auxiliary at Indiana University Medical School. It thus became one of the 45 chapters of a national organization known as the WA-SAMA, Woman's Auxiliary to the Student American Medical Association.

The purpose of the organization is to establish a closer relationship with the wives of the medical students, interns, and residents, the local medical profession and their families, for mutual benefit; and to educate the medical wife in the problems, responsibilities, and the various organizations of the profession her husband is about to enter.

Mrs. Warren Bowers (Sue) is president of the chapter which now has about 50 members. Mrs. Frank Gastineau has been appointed Liaison Officer between the ISMA Auxiliary and the SAMA Auxiliary.

The ISMA Auxiliary will be a guiding hand to the new chapter. Through Mrs. Gastineau, we shall encourage the members in a service program somewhat similar to our own. Already their interest and participation in legislative issues relating to health problems has been notable.

Mrs. Gastineau has found that the chapter's immediate need is financial. To meet this need, the members are planning a card party for October 18. Members of our Auxiliary are urged to support this project. In addition, our Executive Committee voted in its July meeting to make a token contribution to the fledging organization.

With warm sincerity, we welcome these young women. We appreciate that their membership in the Student AMA Auxiliary will train them for effective membership in the AMA Auxiliary.

Eji Kentner



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Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959.

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Is The Effort Worth It?

HON. DURWARD G. HALL, M.D.

Missouri

I DON'T WANT to presume to criticize, in fact I would like for this to be a non-partisan talk, simply calling a spade a spade, and being right down to earth. I don't want to be prejudiced. I want to be like a book in my grandpaw's library that says, "An Accurate Recounting of the War Between the States from a Confederate Point of View." But I think that since it is worth it, that you would be interested in the fact that there has been a sudden change, and as a preamble to my talk I ask you to reflect upon the fact that I helped Dr. Gus Buie and some of the rest of the delegates of this house, years ago, to perfect the principle of medical ethics. I was a leader, in addition to being president of my own society, in the heights of ethicality within our profession. Far be it from me to have a card with my telephone number or, yes, even my address on it—and then imagine driving down the highway in a campaign car with a big sign on the top of it and meeting a 24-foot billboard that has your ugly picture on it and says:

Vote for Durward Hall.

He is the height of integrity, ability and leadership.

And here is his telephone number.

It takes some rather sudden changing within as well as without. Imagine going with me to make a speech at a coon hunt in Barry County, where I was born, down in the Ozark Hills, and getting up nine days after an operation on your knee from an old football injury at Drury College. I bayed against the hounds to these people, who were restless anyway with the winds

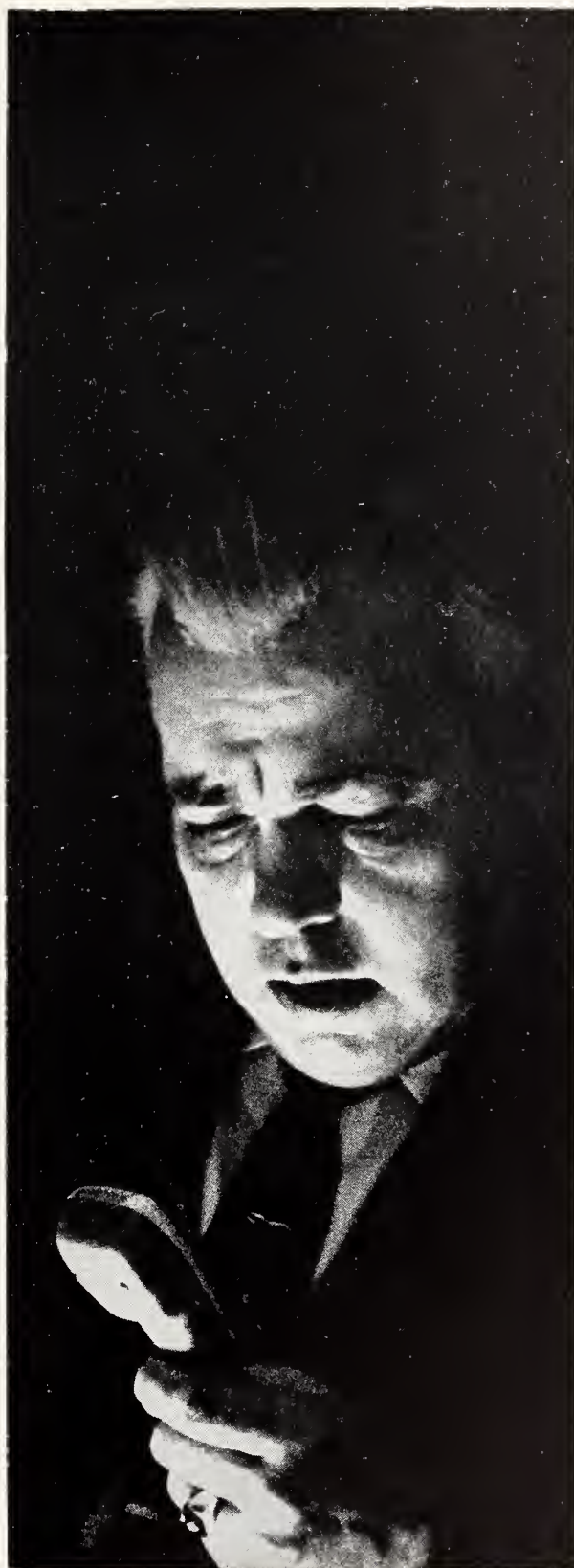
and the trees from over yon hills, and then had to jump off this truck-bed, as we call them down there, and tore sutures out against my partner's advice—imagine how much I was in the doghouse. But this is part of the game and it is fun and it is stimulating and we love it.

So we come up to the question of "Is it *worth* it," and what is the citizenship responsibility from a doctor's point of view? It is an awakening, not only to Madison's encroachment, which is now pell mell, as I shall relate, but it is an awakening after a long Rip-van-Winkle-like nap to the basic duties of American individuals, if our carefully nurtured way of living in a republic on a competitive enterprise basis is to survive. "It *is* worth it." I predict that such awakened citizenship responsibility will toll the death knell of 28 years of living in the "silver spoon" era of regimentation, free spending, higher and higher taxes, conscription, hand-outs, deficit financing, and that we will turn back, not to the good old days but away from the welfare state on whose abyss we totter to the sound and conservative and constitutional basic laws of a healthy market place on God-given laws of supply and demand and coupled with progress.

Responsibility is Participation

Citizenship responsibility, means participation by all on an informed basis. It was Lord Brougham who said that, "informed people are easy to lead, and difficult to drive; easy to govern, and impossible to enslave!" It means participation in the local grass roots mechanics of government to the end that responsible citizens will send the *right* men to our local, state and national legislatures instead of trying to change their spots after they get there. Such

Delivered before the Conference of Presidents and Other Officers of State Medical Associations, Statler-Hilton Hotel, New York City, June 25, 1961.



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New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

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IS IT WORTH IT?

Continued

groomed and selected persons who are to represent us properly must be well versed in economic understanding of our country and in from what it derives.

In my travels both before and after the election I sensed and felt this same ground swell that Mr. Wright talked about. I believe it is popular and that the fields are ripe for harvest and I am of the considered opinion that now *nothing* can stop us.

We *are* responsible Americans, whether we be doctors or peanut vendors, and we can no longer afford to be smug and complacent—yes, prudish, if you please—in the belief that with local consent and a few dollars distributed aimlessly from our *largesse* that we can change the “leopard spots,” of those who owe their election to special-interest groups seeking their own selfish ends.

Well then, *why*, may you ask, the need for an awakening of this sense of citizenship responsibility? After having practiced surgery, along with many of you, for over 26 years and giving up that practice, as was related, and especially having *been elected*, and having bared my chest and campaigned on the fact that I was proud to be a doctor—albeit I wish your support had been a little greater at those critical times when we were paying for television programs, and so forth—and having been a conservative; and *then* observed at first hand for the last six months the way events in Washington are shaping up, and shaping our very lives, I think you will be interested in these observations, remembering that I haven't been there long enough to become *cynical* or *hardened* to what is happening, but have been challenged, excited, and stimulated.

No one can sit in Congress for very long without realizing that we are far from being rid of an experiment in socialism, the welfare state that began under the New Deal, and that there are in fact evil forces working a militant will against the principles set down by our Founding Fathers. I refer to the socialists, or those who weakly disguise their admiration for socialism by referring to themselves as liberals. Organizations such as the Americans for Democratic Action. They are real, they are not just fancy. Also we no longer have government directly responsible to the people, such as men like Franklin, Jefferson and Madison envisioned

when they drafted the framework of our republic. Instead we have a government responsible to organized well-financed pressure groups, each one exerting a powerful influence upon the election of men who decide our national policies and continuing to exert that influence upon whom they elect and appoint. Where were you and yours? “*Is it worth it?*”

Take, for example, just a few of the major legislative issues before Congress today: the Minimum Wage Bill, the Depressed Areas Bill, the Medical Care for the Aging Bill under Social Security, the Federal Aid to Education Bill. Who does the Congress hear from on these issues? From the people, or from the people who for the most part are simply “parroting,” what they are told is *best* for them by the leaders of the particular pressure group to which they are tied? And then, perhaps in self-defense (but a fact), those who *still* believe in constitutional and conservative government have been forced to direct their own professional or trade groups into the field of lobbying, which is an honored and a valuable part of our system; and so it is that our American Medical Association, the Chamber of Commerce, the National Association of Manufacturers and the Farm Bureau and *others*, have turned their attention more and more into the field of national legislation while trying to preserve state rights. After all, the very survival of our way of life is at stake.

“It *was* worth it,” but the lesson to be learned is simply this: as long as those who believe in limited and constitutional government, built upon the *dilution* of power (if you please), rely only on their *particular* lobbying group to offset what other pressure groups are doing, they are fighting a losing battle! Even though you may *slow* the tide toward socialism, you will *not* divert it and the reasons can be found in the simple mathematics which are so important in all politics, at least the ability to “tote the vote,” both pro and con.

Left Wingers More Numerous

The total sum of the people represented by the left wing pressure groups outnumber—at least are more militantly organized and dedicated and certainly more vociferous—the total represented by those who believe in constitutional government, even though in many cases the people who belong to these groups don't understand the

Continued on page 1316

leads to visceral distress...

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IS IT WORTH IT?

Continued from page 1312

depth or meaning of the issues involved, and there is a vacuum and a void of capable leadership.

You *must* recognize, ladies and gentlemen, that the AMA, for example, will never convince the leaders of the UAW and Mr. Reuther that it is right and he is wrong. What you *must* do, therefore, as individual citizens, is to convince *other* individual citizens in these "opposing pressure groups," of the soundness and the validity of the principles for which you stand, the *facts*, not politically generated issues, and *you must be* able to tell the difference.

Never before, in my opinion, was personal contact—people talking to people—more important than in this war of ideas. Members of the UAW do not receive our professional publications. They receive Mr. Reuther's publications! So you cannot reach them through our newspaper, the *AMA News* as good and basic, and right as we are sure it is.

Is our case then hopeless as we attempt to make the general public understand the drastic effect on the quality of medical care which government control of medicine will have? Well, of course not! Professional men, doctors, lawyers, merchants and chiefs, regardless of what you may think, are still held in the highest esteem by the average citizen.

I'm not very interested in all this discussion of posture and image and whether or not the doctor has fallen off the pedestal. The average auto worker, based on what he is told by Walter Reuther, will distrust the AMA, but you can bet your boots that he will still have a high regard for his own doctor, individually. If properly informed, he is not easily led astray and never driven from this opinion.

He may shy away from the American Banking Association, but he respects the advice and judgment of his banker!

So, recognizing that professional organizations are one of the greatest tools available for becoming informed and effective in learning and keeping abreast of the issues of the day, we must take the next logical step of becoming evangelical outside of our own professional circles.

There is a tremendous need in the political parties for the skills and energies and judgment of men like yourself. In the party of your choice,

by attending meetings and rallies and by active participation in campaigns, you can influence the selection and election of good men. After all, politics, properly defined, is just the mechanics of good government. There can be no such thing any longer as being too busy. If you say you are too busy for politics it is like the drowning man professing no interest in water.

Socialization Part of Issue

So what then is the challenge of our time? The basic, yet overriding issue is, whether we shall continue along the path of constitutional representative government in a republic, as envisioned by our Founding Fathers; or whether we will resort to the dictatorship of a questionably benevolent one-party system. *This* is the issue, not just socialized medicine or federal aid to education, or the others.

Now, make no mistake about it, that is exactly the direction in which we are being taken by the "new frontier," and its host of central government advocates, including the foreign give-aways (for social and cultural reform), back-door spending raids on the Treasury, higher taxes, less incentive, phony issues for more votes, and welfare-status! Then how, you may ask, with all the protections given us by our Constitution, is it possible for all the collectivists to take our liberties and our freedoms away? Well, let me illustrate some of the methods that I have just observed, in addition to the apathy, in addition to the complacency, in addition to the general disease affecting the people of the United States of "tranquillo-rectum!"

The Founding Fathers envisioned a government based on dilution of power with a built-in system of checks and balances whereby the legislative, judicial and executive branches would act as restraint one upon the other. They believed in the natural law that, "power corrupts, and absolute power corrupts absolutely!"

Through political deception and "packing" over a 28-year period the radicals have infiltrated the Supreme Court to a degree that it no longer represents a restraint on the actions of *those who* would usurp the power of that document, of the legislative branch, of the sovereign states, or of the individual. The Court which once was the marvel of the world under a long list of distinguished jurists, such as John Marshall and Oliver Wendell Holmes, is now little more than



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IS IT WORTH IT?

Continued

a rubber-stamp for those who would pre-empt all of our existing state law for federal law.

And the Legislative Branch, our branch of the Government, during this most recent session, approved expansion of our entire Federal Court structure by giving the Administrative Branch a free hand in the appointment of 89 new Federal judges sympathetic to its policies and politics. O more, O tempora, where are our Statesmen?

In just a few short months as a Congressman, I have seen a few of the methods which the collectivists are using in the other arm of restraint of the executive—on the Legislative Branch.

Perhaps you suffer from the delusion that no threat exists, at this time to our system of free choice of medical care, the system which, without third parties, has given this nation's people the highest quality of care, the longest life expectancy, and the like of which care exists in no other nation in the world. Well, let me correct here and now that cozy feeling that there is still time, or that our top people will take care of it. I would like to do this by pointing out that there is a very definite possibility that the Senate will tag on the Administration's Medical Care for the Aging Program as an amendment to one of the Social Security bills already passed by the House.

Senator Humphrey stated this, and he is the only man I think of who always walks to the *left* of the President. Now, this is a bold-faced admission by an Administration spokesman that it intends to subvert a basic principle of the Constitution, that all tax legislation shall originate in the House of Representatives.

Not Out of Woods

Be assured, gentlemen, that this nation is not *out* of the woods on this legislation. We have some people in our own party that may submit legislation in the interests of political expediency—and one of them lives not very far from here. We are *not* out of the woods on this legislation and to feel cozy or to believe this would be to demonstrate an incredible lack of understanding about the determination of the proponents and their procedural cunning; their complete lack of principle, their realization of,

and cunning action toward, the chance of (the fluke of), a lifetime. They waited eight years for it!

I have seen countless examples of the Administration shuffling bills by adding "sweeteners" to force the Congress to accept the bad or reject the good. Still another example of reducing the legislative opposition is being accomplished by the simple expedient of withholding needed public works projects until a recalcitrant Congressman "comes around!"

I can think of no better example than what was done just two weeks ago to my good friend and colleague Bruce Alger, of Texas, when the Public Works Committee on a straight party line vote, revoked plans for a needed Federal office building in Dallas; even though the need for such a building as an economy action had been approved by every Federal Agency since 1954 and even had the one-time support of the then Senator Johnson himself.

All the old-timers on the House floor tell me it is the first time in the history of their memory at least, that they have seen Cabinet members in the speakers' lobbies during sessions calling "defectors," off the floor one at a time for executive whipping into line. It takes a strong man, not a political expedient, who was just available to fill a void.

Still another method of the one-party dictatorship that I fear, and that threatens us; is the practice of stacking the Conference Committee, which must reconcile the differences between the House and Senate on any particular bill. On the Minimum Wage Law the Speaker appointed the same conferees who were the floor leaders for the very legislation that the House defeated. After that it is a question of accepting it or rejecting it!

Other examples: You may recall the propaganda at the beginning of this session, about how the Rules Committee needed to be expanded so the House could "work its will!" What has happened instead is that the House now works its will *only* on those bills which the Administration wants, and even then under *closed* rules-of-procedure which do not permit members an opportunity to vote out the bad portions (or leave in the good portions), of a particular bill. Well, with hindsight being like 20/20 vision, there is no longer any question but that this should have been the Administration's first defeat in this



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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," *Cur. Ther. Research*, 2:51, 1960.

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IS IT WORTH IT?

Congress and the Speaker forced to *purge* instead of *pack*. Continued

Try to get a back-door spending protective bill out of the Rules Committee now! There were 125 signers of such a petition the other day. We haven't even heard from the petition!

Last Wednesday evening, when the Congress was on special orders, the Majority Leader slipped in and without objection packed the Committee of the House on Interior and Insular Affairs. Watch and see what happens to the Burns Creek dam and whether Hamar Budge comes back to Congress or not.

New "Vest Pocket Approval"

For the first time the President of the United States has asked the Congress of the United States, ladies and gentlemen, *not* to make laws but to simply give its tacit consent by not taking any action against administrative recommendations! This is known as the executive order under a 60-day period. We no longer have a "vest pocket veto," to support good legislation. Instead, we are now living under the rule of "vest pocket approval," and anyone who has seen the House tied up in knots over the most intricate legislative and parliamentary maneuvering knows that a very few men could prevent the House from taking *any* action, good or bad, on any particular recommendation for at least 60 days.

And then finally I have seen good men, from the other side of the aisle, if you please, vote their convictions, then with tears in their eyes walk up to the well in the fourth time around of any vote, after the measure has been thoroughly beaten, and under pressure by the Administration change their vote from "yea" to "nay." It happened just two weeks ago when the record vote showed sufficient strength to end the war-time excise taxes. The Administration pressured some of its ordinarily right-thinking but weak-gutted Jeffersonians into changing their vote, in "quantity sufficient!"

And I am tired of hearing about a coalition because by definition coalition means something that flows in all directions, and you can't have a coalition that just flows one way, the way they want it to!

What I am saying to you is simply this: The dangers are *too grave*, the stakes are now too high, the time is too late for you, and you, and

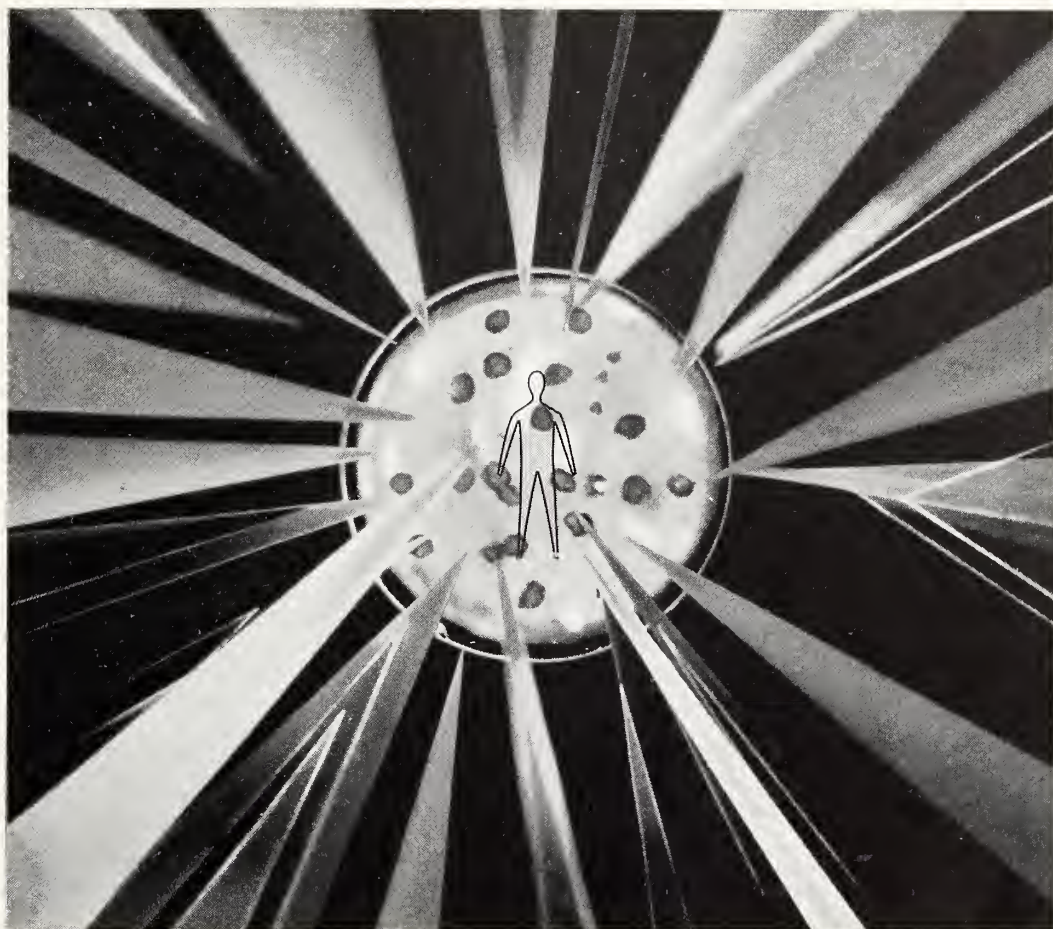
you to simply practice medicine any more; or simply concern yourselves with legislation affecting the medical care of your patients. You, as doctors and secretaries, as professional men held in high regard in the communities in which you practice, can be powerful supporters of the constitution, of conservative government in our country; but to do this you must be as informed on Federal aid to education, on minimum wage legislation, on depressed areas legislation and on all other legislation as you are on the medical care of the aging under social security. The battle you are fighting in favor of high standards of medical care is not against the cause, as was so beautifully stated by our guest speaker here today; but the battle you are fighting, if you fight only against medical care of the aged under social security, is against one of the symptoms. It isn't basic!

Every one of you were taught to get to the basic cause of disease and not be concerned or led astray by the red herrings of symptoms. The bill to place medical care under Social Security is spawned, is originated, is conceived by the same groups and under the same philosophy that want to give the Federal Government control and responsibility for housing, that wants to give the Federal Government control and responsibility for all labor laws, that wants to give the Federal Government control and responsibility for every phase of human endeavor from the cradle to the grave. They said so. All you have to do is look and listen and add up the cost.

Differentiate Symptom from Cause

As one of you who has practiced for many years and who will again, I felt compelled to leave my profession temporarily to enter the battleground on which our whole future and that of our children is at stake. You are not being asked to do this. I don't necessarily recommend it. You are only being asked to demonstrate the same sense of citizens' responsibility that seven of our colleagues showed 200 years ago when they signed the Declaration of Independence, and the six, including the one that you will hear hereafter, that now serve in the House of Representatives as men of medicine. You, more than anyone else, should differentiate the symptom from the cause. The cause demands something more, than what you are now giving, to treat more than just symptoms. It involves the total team and a total cure!

Continued



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Surgical Technic, Two Weeks, November 6
Surgery of Calan & Rectum, One Week, November 27
Gallbladder Surgery, Three Days, October 9
Surgery of Hernio, Three Days, October 12
Basic Principles in General Surgery, Two Weeks,
October 16
Surgical Board Review, Part I, Two Weeks, November 6
Surgical Board Review, Part II, Two Weeks,
November 27
General Surgery, One Week, October 30
Hand Surgery, One Week, October 9
Gynecology, Office & Operotvie, One Week, October 23
Vaginal Approach to Pelvic Surgery, One Week,
October 2
Obstetrics, General & Surgical, Two Weeks, October 9
Basic Electrocardiography, One Week, October 2
Internal Medicine, Two Weeks, October 16
Proctures & Traumatic Surgery, Two Weeks, October 23
Thoracic Surgery, One Week, October 16
Advances in Surgery, One Week, October 23
Advances in Medicine, One Week, November 27
Clinical Uses of Rodioisotopes, Two Weeks, October 2
Blood Vessel Surgery, One Week, November 13
Urology, Two Weeks, October 23

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IS IT WORTH IT?

Continued

What I have tried to say is that the time is long since past, Mr. President, to think that you can save medicine while our other institutions are falling apart, and falling down around us. The time is here when you must become the precinct captain, the man that rings doorbells, like our lovely ladies do so often, on behalf of the political party, the party of your choice, or the candidate that you have helped select; you must be the man who organized committees on their behalf and work with them and be an organizer yourself; or the one who forms groups and simply believes in conservatism and the constitution of the United States, which I think of as second only to the Bible itself, one of the truly great writings of all time.

If you delay, if you procrastinate, you will one day be reminded of the statement of Dante, that the hottest places in hell are reserved for those who in time of moral crisis, did nothing.

So, get off your largesse. It is worth it to you. It is worth it, to us, to the U.S.A., and to the world. In fact, I am convinced it is the *Lord's work*.

So I say:

When, if not now?

Where, if not here?

Who, if not you?



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Your Cholesterol Depressant Diet Book

Menu plan for

Mrs. John Doe
DATE Feb. 1961

JOSEPH ROE

M.D.



1200 CALORIES		1600 CALORIES		2000 CALORIES	
breakfast	112 cup grapefruit sections *Egg 1 egg Coffee or tea with 3 drops, skim milk	70 30 10 TOTAL 110	112 cup grapefruit sections *Egg 1 egg Coffee or tea with 3 drops, skim milk	70 30 10 TOTAL 110	112 cup grapefruit sections *Egg 1 egg Coffee or tea with 3 drops, skim milk
lunch	4 oz. tomato juice 2 oz. drained tuna fish, surrounded with raw vegetables with 1 tbsp. French dressing 1 tsp. water Coffee or tea with 3 drops, skim milk	70 50 20 10 TOTAL 150	4 oz. tomato juice 2 oz. drained tuna fish, surrounded with raw vegetables with 1 tbsp. French dressing 1 tsp. water Coffee or tea with 3 drops, skim milk	70 50 20 10 TOTAL 150	4 oz. tomato juice 2 oz. drained tuna fish, surrounded with raw vegetables with 1 tbsp. French dressing 1 tsp. water Coffee or tea with 3 drops, skim milk
snack	(May be had at mid-afternoon or evening) 8 oz. skim milk	90 TOTAL 90	(May be had at mid-afternoon or evening) 8 oz. skim milk	90 TOTAL 90	(May be had at mid-afternoon or evening) 8 oz. skim milk
dinner	*2 1/2 servings Pickled Beets and *2 1/2 servings Baked *Baked Chicken Breast *Baked Asparagus 1 medium potato, baked Coffee or tea with 3 drops, skim milk	70 30 50 40 10 TOTAL 200	*2 1/2 servings Pickled Beets and *2 1/2 servings Baked *Baked Chicken Breast *Baked Asparagus 1 medium potato, baked Coffee or tea with 3 drops, skim milk	70 30 50 40 10 TOTAL 200	*2 1/2 servings Pickled Beets and *2 1/2 servings Baked *Baked Chicken Breast *Baked Asparagus 1 medium potato, baked Coffee or tea with 3 drops, skim milk
snack	8 oz. skim milk	90 TOTAL 90	8 oz. skim milk	90 TOTAL 90	8 oz. skim milk
TOTAL CALORIES FOR DAY		350	TOTAL CALORIES FOR DAY		450
Total fat calories 71% of energy			Total fat calories 71% of energy		
Total polyunsaturated 40% of fat			Total polyunsaturated 40% of fat		
Saturated 60% of fat			Saturated 60% of fat		

Menu 1
lunch substitution

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Special Plan for Connecticut

One of a series prepared by Blue Cross-Blue Shield

(Note: Commercial insurers based in Connecticut plan to provide major medical coverage for senior citizens of that state. Fundamental weaknesses in their approach to the problem are pointed out in the following critical analysis made by Harry Hineman, Indiana Blue Cross-Blue Shield Actuarial Division Director. This analysis was made in answer to a request by the National Association of Blue Shield Plans.)

The insurance industry should be complimented upon their proposal to provide prepayment of health care on a non-profit basis for persons over 65. It is encouraging that our commercial friends finally recognize that prepayment should be on a non-profit basis. We are eagerly awaiting the extension of this concept to other groups.

Discussion of a benefit program can be more enlightening if we first define the population group we intend to reach. A three-classification break would be useful for this purpose: (1) persons indigent and near indigent, (2) persons with incomes or resources at subsistence level and slightly over, and (3) persons with continuing incomes or resources above subsistence level. Exact family incomes are impossible to assign to each category, but a rough approximation might be as follows:

1. Under \$1,000 per year
2. \$1,000-\$3,000 per year
3. Over \$3,000 per year

To achieve the goals as stated by the AMA "prove to be an answer to proposals to tie medical care for the aged to the Social Security System," our insurance plan must have maximum acceptance by the segments having the greatest need and least coverage by present government and insurance plans.

It is very apparent that persons in category (1) now have complete care provided by public assistance programs or will have comprehensive care under the so-called Kerr-Mills Act. These people will reject any plan which provides lesser benefits or require any payment.

The people in category (3) would appreciate such a plan because the non-profit approach would reduce costs or perhaps increase benefits. At least, they would feel that they were no

longer fair game in the sharp underwriting of health insurance.

Great numbers of people in category (2) are the ones we need to reach because each has little income and few are enrolled in present health care plans. The health needs of this group are also great as shown by the National Health Survey: "The Survey also shows the relationship between family income and chronic illness, by age—with the lowest income aged experiencing the greatest proportions of chronic conditions."

How much does complete medical care for persons over 65 cost? The Social Security Administration has estimated this per capita cost to be approximately \$22 per month; the Department of Public Welfare for Indiana has estimated this cost to be \$45 per month for persons in category (1). The Social Security Administration recognized that the National Health Survey considerably understated the dimension of the health problem for the aged; the Survey also indicated that per capita costs for persons in categories (2) and (3) will be less than those for persons in category (1). The true per capita costs for persons in category (2) are probably between the two extremes in a range estimated to be \$28 to \$35 per month. Insuring for these costs will in no way reduce them. In fact, there's considerable evidence to support the contention that insurance, which depends upon economic controls, will increase them.

The Connecticut insurers propose to offer "low-rate health insurance to the state's aged." Insurance does not provide a financial miracle any more than quack doctors provide a medical miracle—(1) Either the per capita cost is paid in premiums, (2) some other population group provides a subsidy, or (3) benefits are reduced to the level of a predetermined premium. Blue Cross-Blue Shield and governmental plans have always taken the subsidy approach with varying limitations on benefits. It has been stated that the Connecticut Plan of the Insurance Companies is to be experience rated and, therefore, alternative (3) only can be adopted. Using alternative (3), the non-profit approach is not enough to keep benefits and premiums in an acceptable range for a solution to the problem. A subsidy of

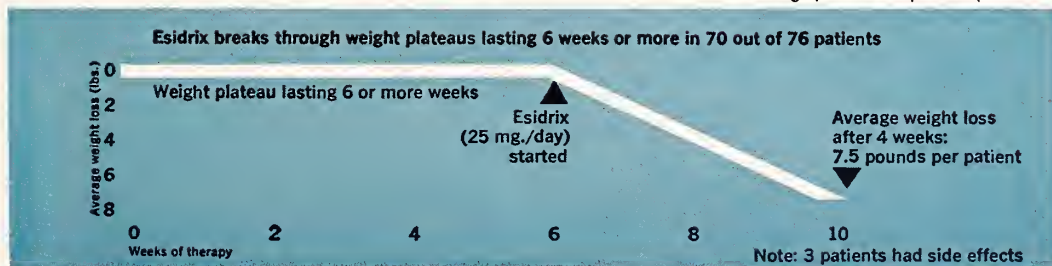
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1. As an adjuvant in initiating treatment: Esidrix induces greater weight losses in the first few days than a conventional regimen.¹ This weight loss may be significant in itself (depending on the degree of fluid retention). But more than that, the quick loss of even a few pounds builds confidence in the weight-reducing program, inspires determination to follow it faithfully.
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(Adapted from Einhorn and Kalb²)



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References: 1. Ray, R. E.: To be published. 2. Einhorn, H. P., and Kalb, S. W.: Clin. Med. 7:1995 (Oct.) 1960.

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CONNECTICUT PLAN

Continued

at least five percent of total group health insurance premiums will be needed just to make the offering respectable.

A major medical approach requires the use of deductibles and co-insurance. Since this program is designed for low income persons having very high health care costs, it is important to consider who will pay the deductibles and co-insurance. The economic status of the patients eliminates most of them immediately. Obviously, the provider of services must absorb these as a bad debt and increase prices to offset them.

Since the economic status of patients also will require assignment of benefits, another interesting question develops—whose services will the deductible apply against?

If an insurance program using deductibles and co-insurance ever could have solved the health financing problems for persons over 65, we certainly would not be in such critical position today. To my mind, these devices are a primary cause, not the solution.

If we assume that a health financing problem really exists, we should develop our program to protect the interested parties in the following priority:

1. Protect first the individual over 65.
2. Protect second the community and providers of service,
3. and protect last the insuring organization.

To protect the individual, we should provide a broad range of benefits, pay as nearly as possible the total bill, and provide some subsidy through our rating mechanism.

To protect our community and providers of services, we should design our program to pay the regular charges for services rendered consistent with income level of the patient.

To protect the insuring organization, we should install limitations and controls on eligibility and benefits so that the program actually is useful only to the people it is designed to help.

A program of this type should be of great interest to the medical profession because it encourages and requires responsible action in the practice of medicine, not the irresponsible action of the wide-open insurance approach.

The American Medical Association has already, in fact, endorsed such a program of action. The House of Delegates at its 1958 meeting voted to adopt a resolution to provide service benefits at a reduced rate to persons over 65, with "modest resources and low family incomes."

This program is for people. ◀

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Dr. Wood Appointed to Seven-Member AMPAC Board of Directors

Dr. Don E. Wood, Indianapolis, current chairman of the ISMA Executive Committee and co-chairman of the Commission on Legislation, has been named to the seven-member Board of Directors of the newly-formed American Medical Political Action Committee, according to a recent AMA announcement.

The committee will serve the medical profession primarily as an educational organization in guiding, assisting and encouraging physicians at state and local levels in developing year-round political action programs.

All licensed doctors of medicine and their wives are eligible for AMPAC membership.

Urological Association Offers \$1,000 in Prizes for Essays

The American Urological Association is offering annual awards of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing clinical or laboratory research work in urology. Animal research is not necessary.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Bellevue-Stratford Hotel, Philadelphia, Pa., May 14-17, 1962.

For further information write the Executive Secretary, William P. Didusch, 1120 North Charles St., Baltimore 1, Md. Essays must be in his hands before Nov. 15, 1961.

Cash Prize of \$500 Offered In Oldest Medical Essay Contest

The Trustees of America's oldest medical essay contest, the Caleb Fiske Prize of the Rhode Island Medical Society, announce two subjects for this year's dissertation, open to any doctor of medicine in the nation, for which a cash prize of \$500 will be awarded. The subjects chosen are: "Recent Advances in the Treatment of Malignant Disease," and "Current Status of Cardiac Surgery." An essay on either subject must be typewritten, double spaced, and should not exceed 10,000 words. Essays must be submitted by Dec. 11 to the Secretary, Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence 3, R. I.

Joseph Palmer Named to New Post On ISMA Headquarters Staff

Joseph E. Palmer, who for more than 12 years was executive secretary of the Marion County Medical Society, has accepted the position of administrative assistant to Mr. James A. Waggener, Executive Secretary of the Indiana State Medical Association.

Palmer, a native of Wabash, started his new duties on Aug. 15.

For the last four years, Palmer has served as field secretary of the James Whitcomb Riley Memorial Association.

Palmer, who resides at 5960 N. Sherman Drive, Indianapolis, is married but has no children.

He attended DePauw University as a Rector Scholar and served in editorial and reportorial capacities with the *Wabash Plain Dealer* and the

Michigan City Dispatch, and was wire editor and a reporter for the Chicago Bureau of the Associated Press prior to World War II.

During the war he served in Africa, Italy, France and Germany in a public relations capacity with the U. S. VI Corps and the U. S. Seventh Army.

Journal Author Named Director of Hospital Education Program

Dr. Jack W. Hickman, author of the *Journal's* regular feature, "Gleaned from the British Medical Journal," has been named director of education at Marion County General Hospital, Indianapolis. Dr. Hickman heads the hospital's training program for interns and residents.

Dr. Hickman is a graduate of the I. U. Medical School. He served a 3-year medicine residency at Lahey Clinic, Boston, Mass., and at General. Until his hospital appointment, he was in the private practice of internal medicine in Indianapolis.

MENTAL HEALTH GRANT TO I.U. IS ONE OF THREE RECEIVED RECENTLY

The I.U. School of Medicine recently acknowledged an \$819,998 grant from the National Institute of Mental Health, to be used for developing a research center to study early childhood schizophrenia.

According to Dean John VanNuys, the grant was the third major research fund received in three weeks. Others were \$4,383,700 from the National Heart Institute for heart research and \$689,000 from the Air Force for studying heart and lung stress in space travel.

Drs. John A. Campbell and Eugene C. Klatte, of the I. U. School of Medicine, have received grants in radiological research given by the National Academy of Sciences National Research Council.

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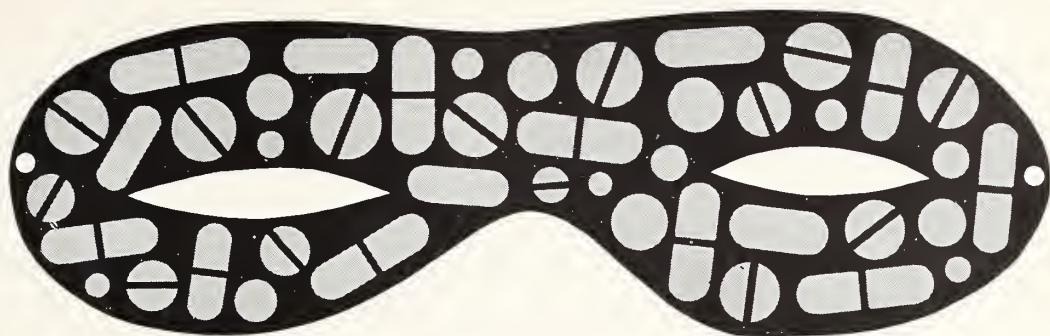


HOME LAWN MINERAL SPRINGS

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Medical Director



drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

“The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost \$28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results.”

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

“... it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . .”

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

“The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned.”

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia



FUTURE MEETINGS, SEMINARS, COURSES

Denver Winter Meeting Offers Excellent Scientific Program

LEONARD W. LARSON, M.D.

President, American Medical Association

The 15th annual American Medical Association clinical meeting in Denver Nov. 26-30 will offer a combination of fundamental post-graduate knowledge plus the latest findings in a number of areas of medical research that will be of great benefit to all of us in the conduct of our practice.

As a former member for many years of the Council on Scientific Assembly, I have followed the progress and development of the winter clinical meeting from its inception. I can state without qualification that the program organized for this 1961 Denver meeting is the best that has ever been assembled.

At the annual meeting in New York last June, the Board of Trustees and the House of Delegates once again put their stamp of approval on the winter clinical meeting as a vital part of the American Medical Association's service to its membership to provide continuing education and knowledge.

It is my personal hope and appeal that every member of the American Medical Association will take full advantage of the opportunities offered at the Denver meeting by attending all five days.

There are many highlights in the clinical programs that will be of value and interest to the clinician.

All of us in practice are well aware that the personal habits of our patients, plus the habits of the social group of which they are a part, play a major role in health.

This phase of medicine has been studied in detail by a group of Colorado physicians, and

they will present their findings in a series of papers at the Denver meeting.

Space medicine is very much in the news these days. Many of us are only vaguely aware that the research specialists in space medicine also are learning much that will be of value to the physician in everyday practice. Several specialists in space medicine will present papers analyzing some of these findings.

Every physician knows that heredity is important in tracing the patient's pattern of disease. The research scientists are now learning much more about this important aspect of medicine, and a section on genes and chromosomes and their implications in disease has been scheduled.

It is now possible to get bids and delivery dates on a full-fledged nuclear power plant for private industry. In fact, at least one of these plants already has been built. In the decade ahead there will be many more nuclear reactors in everyday use in many geographical areas.

Every possible safety precaution is taken in the installation and operation of a reactor, but there always is the human element, and accidents will happen. The physician in practice, sooner or later, likely will be faced with the problem of treating injuries from reactor accidents.

Specialists in this area will present several papers that will give those of us in practice considerable basic knowledge on how to treat patients suffering from reactor accidents.

I have listed only a few of the many highlights of the clinical program for the November

meeting. There will be many other equally interesting and informative presentations.

The winter meeting is designed specially for the clinician in practice. Let me repeat: the program this year is the best in the splendid history of this meeting.

FIRST MILWAUKEE CONFERENCE

The first annual Milwaukee Medical Conference will be held Oct. 19 and 20 at the Milwaukee County General Hospital, with the theme, "All That's New in Medicine." Fourteen nationally-known speakers will discuss newest developments. All members of ISMA are invited to attend.

Three-Day Seminar to Precede RhinoLogic Society Meeting

The American Rhinologic Society will hold its 7th annual meeting at the Belmont Hotel in Chicago Oct. 7. The full day of addresses, panels and conferences will be preceded by a three-day seminar and workshop at the Illinois Masonic Hospital. All physicians are invited to attend. There is no registration fee.

Continued

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ATTENTION, TAXPAYERS!

Non-Defense Government Spending Must Be Stopped

The \$60,225,000 Federal REA loan to 17 Hoosier Electric Co-ops to duplicate existing electric facilities is a prime example of unnecessary and wasteful use of taxpayers' monies. Write to your government representatives and state your opinions.



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FUTURE MEETINGS

Continued

Postgraduate Endocrinology Assembly Oct. 2-6 at Bethesda, Md.

The thirteenth postgraduate assembly in endocrinology and metabolism will be sponsored by the Endocrine Society and the National Institutes of Health at Bethesda, Md., Oct. 2-6, 1961.

A comprehensive review of clinical endocrine problems and current research activity in these areas will be presented. For further information, write to: Dr. Roy Hertz, National Institutes of Health, Building 10, Bethesda 14, Md. The fee will be \$100.00 for physicians, with a reduction to \$30.00 for Residents and Fellows. Enrollment limited to 100.

Medical Librarians Choose Rochester

The Midwest Regional Group of the Medical Library Association will meet in Rochester Minn., Oct. 27 and 28, 1961. Mr. Thomas E. Keys, librarian for the Mayo Clinic is the chairman of the local committee. Inquiries may be addressed to him.

Continued

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Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
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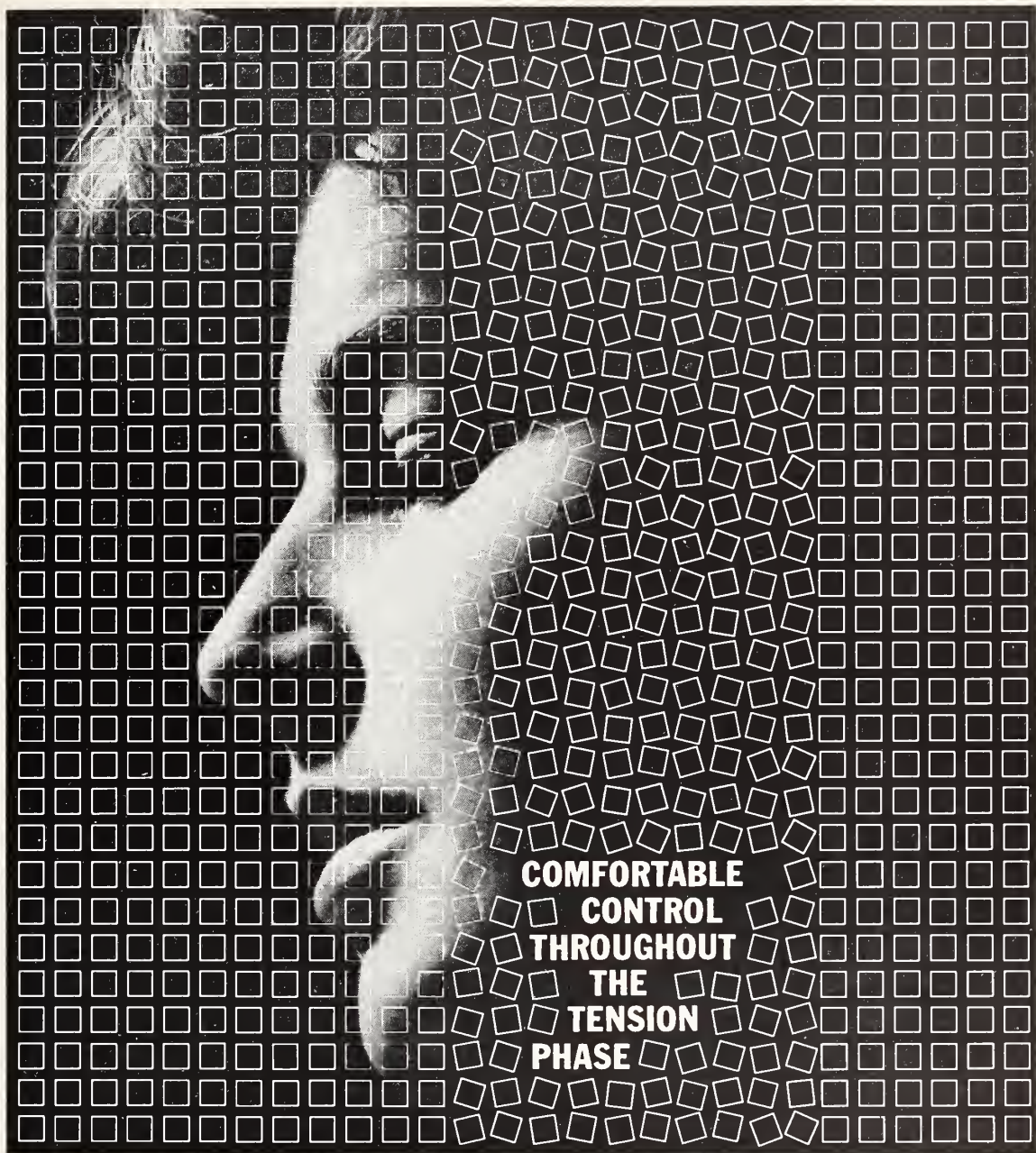
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FUTURE MEETINGS

Continued

AMA Occupational Health Congress To Meet in Denver, Oct. 2-4

The American Medical Association will hold its 21st national Congress on Occupational Health in Denver, Oct. 2-4.

To be held at the Brown Palace Hotel, the three-day meeting is sponsored by AMA's Council on Occupational Health in cooperation with the Colorado State Medical Society.

The congress serves as a meeting for the formal presentation of papers on occupational health as well as a forum in which occupational health problems and questions can receive the attention of acknowledged experts in this field.

A highlight of the meeting will be the presentation at the annual banquet of the award to a physician selected by the President's Committee on Employment of the Physically Handicapped for outstanding contributions to the welfare and employment of the nation's physically handicapped.

The Indiana Division of the United States Section of the International College of Surgeons will hold its annual Regent's Meeting and din-

ner Wednesday, Sept. 27, 1961, at the Columbia Club in Indianapolis.

The scientific meeting will start at 2 p.m. Participants will include Dr. Lawrence W. Long, Jackson, Miss., Regent for the College in his state, who will speak on "Peptic Ulcer—A Plea for Earlier Definitive Treatment." Dr. Edward L. Compere, Chicago, immediate past president of the United States Section, will speak on "Safeguards and Errors in Orthopedic Surgery." Dr. Louis P. River, Oak Park, Ill., clinical professor of surgery at the Stritch School of Medicine of Loyola University, will discuss "Management of Breast Lumps."

The dinner meeting will also be held in the Columbia Club at 7 p.m., preceded by a social hour. Speaker of the evening will be Dr. John B. O'Donoghue, Chicago, secretary of the United States Section of the International College of Surgeons, on "The Surgeon—An International Ambassador of Peace Among Men." Dr. O'Donoghue will be introduced by Dr. W. F. James, Rear Adm. (MC) USN (Ret.), Executive Director of the International College of Surgeons, who will contribute a few remarks on the world-wide service of the College.

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Deaths

Clifford A. Beilke, M.D.

Dr. Clifford A. Beilke, 42-year-old East Chicago physician, passed away July 22 following a heart attack. He had practiced in East Chicago for 14 years.

A graduate of the I. U. School of Medicine in 1946, Dr. Beilke was a member of the staff of St. Catherine Hospital. He had held several offices in the local county and state associations for retarded children.

Leon T. Bogmenko, M.D.

Doctor Leon T. Bogmenko passed away in July at the age of 69. He had been medical director of the Indiana Reformatory at Pendleton. Doctor Bogmenko had moved to Madison just prior to his death. He was graduated from the Imperial University in Russia in 1916, and received his Indiana license in 1955.

William Caldwell, M.D.

Dr. William Caldwell, 73, Evansville physician, passed away July 3. Dr. Caldwell was a senior member of ISMA.

Raymond Victor Converse, M.D.

Dr. Raymond V. Converse, Indianapolis general practitioner from 1902 until 1956, passed away July 9 in Los Angeles. He was 85.

Dr. Converse was once Indianapolis police and fire department surgeon. He was a graduate of Loyola University Medical School.

James C. Freed, M.D.

Dr. J. C. Freed, Attica Indiana's only doctor during World War II, passed away July 9 at the age of 71. He practiced in Attica for 30 years, until retiring in 1953.

Dr. Freed was a former teacher, having served as a high school superintendent in the Philippines for three years. He graduated from I. U. School of Medicine in 1915.

Arthur M. Hetherington, M.D.

Dr. Arthur M. Hetherington, a former commissioner of the Marion County Board of Health, passed away July 22 in Indianapolis. He was 80.

A graduate cum laude from the I. U. School of Medicine in 1910, Dr. Hetherington received his 50-Year-Club award last year. He retired in 1959.

Gardner C. Johnson, M.D.

Dr. Gardner C. Johnson, 89-year-old Evansville physician, passed away June 30.

A tuberculosis specialist, Dr. Johnson was the first superintendent of Boehne Hospital in Evansville, from 1915-18. He practiced a total of 47 years in Evansville, retiring in 1955; he received his 50-Year-Club award in 1951.

Dr. Johnson served two terms as president of the Vanderburgh County Medical Society. He was also a former president of the Indiana Tuberculosis Association.

Rex K. Pomeroy, M.D.

Dr. Rex K. Pomeroy, a member of the medical staff at Fort Wayne State School, passed away June 27. He was 58.

Dr. Pomeroy had moved to Fort Wayne two years ago from Plymouth. He was a graduate of the I. U. School of Medicine.

Donald Reed, M.D.

A 60-year-old Culver, Ind., physician, Dr. Donald Reed, passed away July 18. He had practiced in Culver since 1932.

Lewis C. Rentschler, M.D.

Dr. Lewis C. Rentschler, retired Clay City, Ind., physician, passed away July 15. He was 73.

Dr. Rentschler practiced in Clay City from 1919 until 1946. He was active in civic affairs, having been a member of the town board for 20 years.

Dr. Rentschler was graduated from the I. U. School of Medicine in 1912. He served during World War I, then practiced at Center Point before moving to Clay City.

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County News

Harrison-Crawford

Local business and civic leaders were guests of the Harrison-Crawford Medical Society July 13. Following dinner, the group listened to a taped address given by Dr. Edward Annis, Miami, Fla., to Indiana doctors at a French Lick meeting in April.

Jackson

Newly-elected officers of the Jackson County Medical Society are Drs. Harold Miller, president; Harry Baxter, vice president, and Kenneth E. Bobb, secretary.

Dr. Jack Shields will serve as delegate, with Dr. William Scharbrough, alternate delegate.

Committee chairmen include Drs. I. S. Templeton, legislative; H. R. Baxter, public relations; W. D. Scharbrough, rural health; Dr. Bobb, traffic safety; C. A. Wiethoff, insurance; R. O. Bosch, aging; J. B. Butler, grievance; Dr. Bosch, diabetes; Dr. Bobb, school health and physical education; Dr. Bosch, tuberculosis; Dr. Bobb, civil defense; Dr. Butler, conservation of

vision; and J. M. Black, county liaison with Indiana Department of Public Welfare.

Posey

Dr. Harold Ropp is the new president of the Posey County Medical Society. Assisting him are Drs. John Vogel, vice president; Herman Hirsch, secretary-treasurer; Frank Oliphant, delegate, and John Crist, alternate delegate.

HOW IT'S DONE

A doctor was irate when he finally reached his table at a civic dinner after trying to break away from a woman who wanted some advice on a health problem. Seeing a lawyer friend of his sitting next to him, the doctor said:

"These people who are always trying to get free medical advice give me a pain in the neck. Do you think I should send that woman a bill?"

"Why not?" replied the lawyer. "You rendered your professional services by giving her advice."

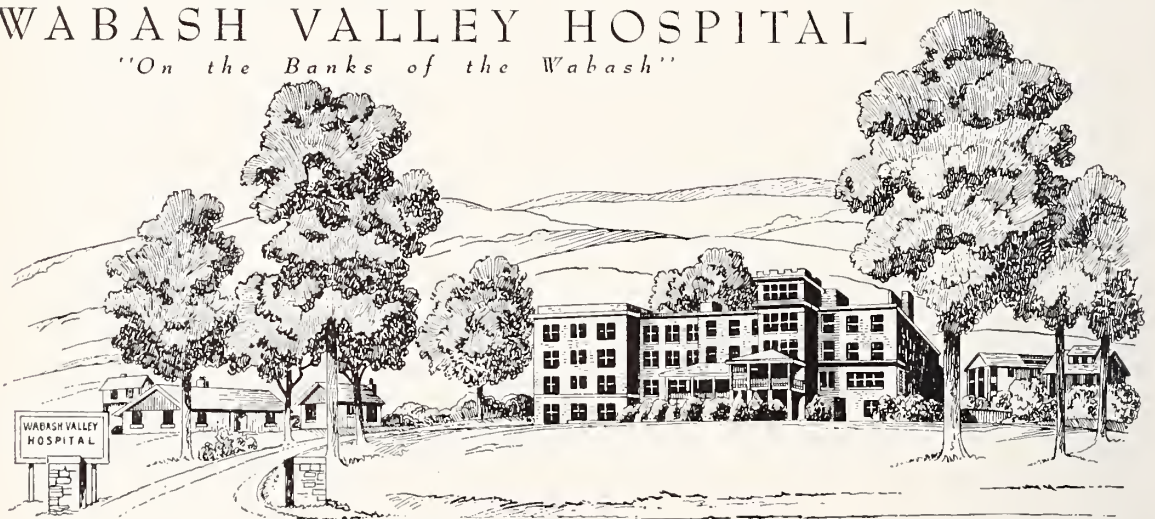
"Thanks," said the physician. "I think I'll do it."

When the doctor went to his office the following morning to send the bill to the annoying woman, he found a letter from the lawyer. It read:

"For legal services—\$25."—*Wall Street Journal*.

WABASH VALLEY HOSPITAL

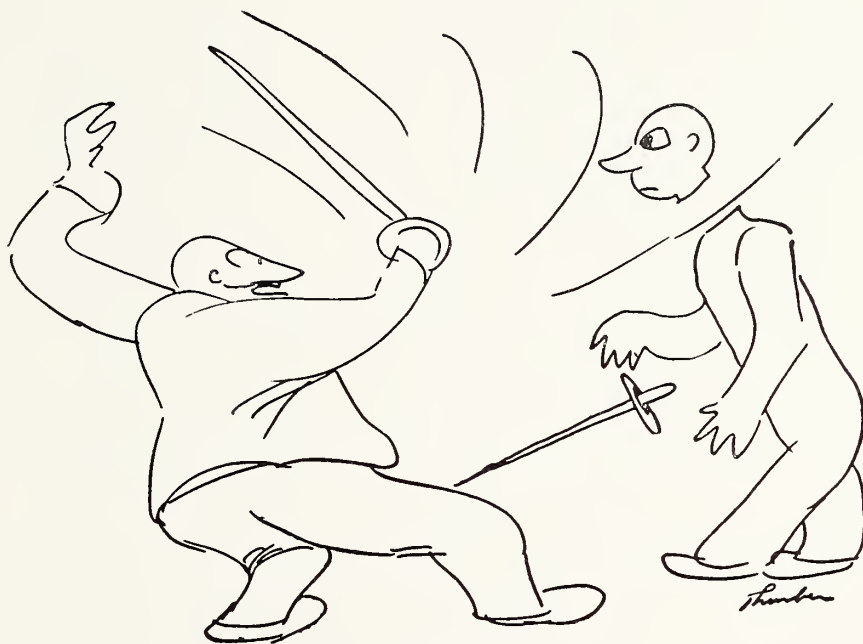
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How Trancoprin relieves pain: Because most pain is accompanied by muscle spasm and tension, good medical practice suggests use of an analgesic that will relax skeletal muscles as well as dim pain perception. Such an analgesic is Trancoprin — a combination of aspirin and Trancopal®, a proved, safe, skeletal muscle relaxant and tranquilizer. Trancoprin can be prescribed for any pain, except pain of such severity that a narcotic is needed.

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Association News

EXECUTIVE COMMITTEE

July 8, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D., and Charles F. Gillespie, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Ralph Hamill, attorney, and James A. Waggener, executive secretary.

Building Committee: Ralph V. Everly, M.D., chairman; R. Case Hammond, M.D.; Harry Pandolfo, M.D., and Jack E. Shields, M.D.

Membership Report

Number of members as of Dec. 31, 1960	4,309
1961 members as of June 30, 1961:	
Full dues paying	3,642
Residents and interns	192
Council remitted	38
Senior	375
Honorary	3
Military	37
Total 1961 members as of June 30, 1961	4,287
Gain over last year	34
Number of members as of June 30, 1960	4,253
Number of AMA members as of June 30, 1960	4,120
1961 AMA members: Dues paying	3,510
Exempt but active	646
Total 1961 AMA members as of June 30, 1961	4,156
Gain over last year	36
Number who have paid state dues but not AMA dues for 1961	125

Building Matters

Dr. Ralph V. Everly, chairman of the Building Committee, appeared before the Executive Committee and reported on the findings and recommendations of his committee at which time he presented the following resolution which had been adopted by the Building Committee:

WHEREAS, the Building Committee of Indiana State Medical Association was empowered and directed to secure a site and build a building for said Association; and

WHEREAS, in the performance of said duties the Committee through its architect secured the sealed bids of five (5) reputable contractors in the Indianapolis area, the lowest of whom was Thomas A. Berling & Sons, Inc.; and

WHEREAS, all of said bids far exceeded the stipulated sum for said construction; and

WHEREAS, this Committee, together with the architect, then entered into negotiations with said lowest bidder to endeavor to secure a bid on a building costing less and within the budget of said Committee; and

WHEREAS, modified plans and modified specifications were drafted and submitted to said Thomas A. Berling & Sons, Inc.; and

WHEREAS, said contractor has submitted a bid of

\$174,000.00 for General Construction Work
 \$ 27,000.00 for Electrical Work
 \$75,000.00 for Plumbing, heating, ventilating and air conditioning (including exterior sewer work)

and

WHEREAS, this Committee is of the opinion that a contract should be entered into immediately with said Contractor on the above terms, except that the electrical item of \$27,000.00 and the plumbing, heating, ventilating and air conditioning item of \$75,000.00 should be resubmitted to subcontractors, with detailed specifications, and this Association would have the benefit of any reduction in the above sums.

NOW, THEREFORE, BE IT RESOLVED, That this Building Committee of the Indiana State Medical Association should enter into a contract with Thos. A. Berling & Sons, Inc. for \$276,000.00 for general construction, electrical work, plumbing, heating, ventilating and air conditioning of said building, in accordance with the plans and specifications, as now modified by Lennox, Matthews, Simmons and Ford, Inc., and subject to the following:

1. The electrical, plumbing, heating, ventilating, and air conditioning (including exterior sewer work) shall be resubmitted to subcontractors and the Indiana Medical Association shall be given the benefit of any reduced price under the quoted \$27,000.00 for electrical work and \$75,000.00 for plumbing, heating, ventilating and air conditioning work.

2. Said contract shall be submitted to the Executive Committee and Council of Indiana State Medical Association for their approval and direction before execution.

3. Said contract shall be approved by the attorneys of Indiana State Medical Association for their approval as to form of the terms and conditions before execution.

4. A performance bond shall be purchased by Contractor on terms and conditions which meet the approval of the attorneys for said Association.

5. On approval of the Executive Committee, Council, and Attorneys of said Indiana State Medical Association, the members of this Committee, together with the President or President-elect and Executive Secretary, shall sign said contract for and on behalf of said Indiana State Medical Association.

(Signed) RALPH V. EVERLY, M.D.

JACK E. SHIELDS, M.D.

R. CASE HAMMOND, M.D.

Dated: July 8, 1961

The executive secretary read a letter which he had directed to the attorneys requesting information on appropriate procedure to be taken in case a contract was signed for construction of a headquarters building, specifically requesting who had the authority to sign such contracts.

Following discussion the Executive Committee adopted the following resolution, upon motion of Drs. Glock and Stimson:



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are too many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's

highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

© Florida Citrus Commission, Lakeland, Florida

*Resolution of Executive Committee of
Indiana State Medical Association*

WHEREAS, the Building Committee of Indiana State Medical Association has submitted their resolution of this date in reference to the building of an association headquarters, a copy of which is attached hereto and marked "Exhibit A," and

WHEREAS, this Executive Committee has studied said resolution thoroughly and has reached a conclusion;

NOW, THEREFORE, BE IT RESOLVED, That this Executive Committee does hereby approve, consent to, and direct the Building Committee, the President, or President-elect, and the Executive Secretary of Indiana State Medical Association to enter into a contract with Thos. A. Berling & Sons, Inc., in accordance with the terms and conditions set forth in said resolution.

Dated this 8 day of July, 1961.

(Signed) DONALD E. WOOD, M.D.,
Chairman

ATTEST:

Jas. A. Waggener,
Secretary

Conference Table: The secretary read a letter from the Industrial Medical Association concerning a 20-foot conference table and 20 chairs which are for sale at an understood price of \$500.00 F.O.B. Chicago. Upon motion of Drs. Glock and Covalt the president-elect was asked to go to Chicago to inspect the table and upon motion of Drs. Stimson and Covalt the Committee voted to purchase the table for the new headquarters building if it is found to be in good condition and is movable.

Headquarters Office

Science Fair expenses: The secretary reported that he had sent a check for \$2,000.00 to Dr. Ralph Eades for Science Fair participation and called attention to the action of the Council when the appropriation was made, stating that the Association would pay up to \$2,000.00 for the transportation of the winners in the biological science fields only. The secretary stated that he had asked Dr. Eades for a report on what had been paid for and from the appearance of the reply the Association had picked up the major portion of the transportation costs for all of the regional winners, no designation having been made as to whether these were winners in the biological sciences or not. On motion of Dr. Glock and taken by consent, this matter was referred to the Council.

Treasurer's Office

The treasurer reported on the statements of income and expenses, and budget balances, as of June 30, 1961, covering the headquarters office, *The Journal*, and the Building Fund, and submitted the auditor's third quarter report, all of which were approved on motion of Drs. Stimson and Covalt.

Legislation

National: Dr. Wood reported on the forthcoming hearings on HR 4222.

Local: Letter from the Davis Clinic and reports of activities of other clinics concerning what the Association would do on legislation which would permit physicians and clinics to have the tax benefits under a corporate structure were brought to the attention of the Committee. This material was ordered to be placed on the agenda for the next meeting of the Committee.

Organization Matters

The offer of the A. H. Robins Company, Richmond, Virginia, to present annually a Community Service Award to an Indiana physician was turned down on motion of Drs. Glock and Covalt.

A letter was read from the U. S. Treasury Department in reply to questions asked by the Allen County Medical Society and the secretary stated that a copy of the letter had been forwarded to the society.

Woman's Auxiliary: A reply to Mrs. Kintner's inquiry concerning tax matters as they affected the Woman's Auxiliary was reported upon, with the information that a copy of the reply had been forwarded to the Auxiliary.

AMA Annual Meeting matters were discussed but inasmuch as the same matters would come before the Council, no action was taken.

Annual Convention, Indianapolis, October 24, 25 and 26, 1961

The sale of exhibit space for the 1961 meeting was noted.

New Business

A discussion was had concerning the operation of the delegation from the Association to the AMA meetings and by consent it was agreed to refer to the Council a recommendation that the Executive Committee be empowered to prepare a manual outlining the operating procedures and responsibilities of delegates to the AMA meetings.

By consent it was agreed that the Council should be requested to approve of the Association paying all or part of the expenses for sending the alternate delegates to the AMA meetings.

On motion of Drs. Glock and Stimson it was agreed that the AMA delegates and alternate delegates be notified to meet with the Executive Committee at its meetings held prior to the interim and annual meetings of the American Medical Association.

Blue Cross Hospital Service: A letter was read from Dr. Case Hammond concerning the recent communication from Blue Cross to all hospital administrators in which Blue Cross informed the administrators that Blue Cross patients would not be paid for by Blue Cross for stays exceeding 15 days unless prior approval was granted, meaning that physicians would have to request in writing on the fourteenth day an extension of time for patients to remain in hospitals at Blue Cross expense. Upon motion of Drs. Glock and Stimson this matter was to be referred to the Council with the recommendation that the physicians of Indiana ignore this directive.



"NO ONE'S GOING TO PULL THE WOOL OVER OUR EYES — WE KNOW
BLUE SHIELD IS THE BEST DEFENSE AGAINST SOCIALIZED MEDICINE!"



Blue Shield

Mutual Medical Insurance, Inc.
110 N. Illinois St., Indianapolis 9, Ind.
Phone MElrose 5-9411

Sponsored by the Indiana State Medical Association

The Journal

It was announced that the editor, Dr. Frank Ramsey, had been elected to the advisory board of the State Journal Advertising Bureau.

A letter requesting the secretary to chair a session during the State Journal Advertising Bureau annual meeting was read and acceptance was approved on motion of Drs. Stimson and Covalt.

THE COUNCIL

July 9, 1961

The Council of the Indiana State Medical Association convened for its summer meeting at 10:00 a.m., Sunday, July 9, 1961, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Maurice E. Glock, chairman, presiding.

Roll call showed the following present:

Councilors

First District—William B. Challman, Mount Vernon

Second District—E. T. Edwards, Vincennes

Philip T. Holland, Bloomington, alternate

Third District—John M. Paris, New Albany (also AMA alternate delegate)

Fourth District—Joe M. Black, Seymour

Fifth District—V. Earle Wiseman, Greencastle

Sixth District—William R. Tindall, Shelbyville, alternate

Seventh District—Ralph V. Everly, Indianapolis

Eighth District—Gordon B. Wilder, Anderson (also AMA delegate)

Ninth District—Kenneth O. Neumann, Lafayette

Albert E. Stouder, Kempton, alternate

Tenth District—Ralph C. Eades, Valparaiso, alternate

Eleventh District—E. S. Rifner, Van Buren

Twelfth District—Maurice E. Glock, Fort Wayne

Milton F. Popp, Fort Wayne, alternate

Thirteenth District—Burton E. Kintner, Elkhart

Officers:

Harry R. Stimson, Gary, president-elect

Irvin W. Wilkens, Indianapolis, treasurer

Charles F. Gillespie, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor, *The Journal*

Executive Committee:

Don E. Wood, Indianapolis, chairman (also co-chairman, Commission on Legislation)

Wendell E. Covalt, Muncie, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate

E. S. Jones, Hammond, AMA delegate

Gordon B. Wilder, Anderson, AMA delegate

Wendell C. Stover, Boonville, AMA delegate

Philip B. Reed, Indianapolis, chairman, Grievance Committee

John D. VanNuys, Indianapolis, Dean, I. U. School of Medicine

A. C. Offutt, Indianapolis, State Health Commissioner

Emett B. Lamb, Indianapolis, chairman, Commission on Public Health

Richard Swan, Anderson, member, Commission on Public Health

Future Meetings

AMA Institute, Chicago, Aug. 31-Sept. 1, 1961. Upon motion of Drs. Wilkins and Covalt it was agreed that the field secretaries should attend the AMA Institute in Chicago Aug. 31-Sept. 1.

There being no further business the Committee adjourned to meet again upon the call of the chairman, with a tentative date set for Aug. 23, 1961. ◀

Gerald F. Kempf, Rockville, member, Commission on Public Health

James O. Ritchey, Indianapolis, chairman, Special Sub-committee of the Student Loan Committee

Nathan Salom, Ft. Wayne, chairman, Commission on Aging

Jack E. Shields, Brownstown, member of Building Committee

R. Case Hammond, Evansville, member of Building Committee

Staff:

Ralph Hamill, attorney

Robert J. Amick, field secretary

Howard Grindstaff, field secretary

J. A. Waggener, executive secretary

On motion of Dr. Paris, seconded by many, minutes of the April 9, 1961, Council meeting were approved as printed in the June, 1961, issue of *The Journal*.

Reports of Councilors

The following announcements were made by the councilors:

John M. Paris was re-elected councilor of the Third District for the three-year term ending October, 1964.

K. O. Neumann was re-elected councilor of the Ninth District for the three-year term ending October, 1964.

Milton F. Popp, Fort Wayne, was elected councilor of the Twelfth District for the three-year term ending October, 1964.

John L. Langohr, Columbia City, was elected alternate councilor of the Twelfth District to fill the unexpired term of Dr. Popp.

Elections to Blue Shield Board of Directors—3-yr term ending March, 1965:

Fletcher W. McDowell, Muncie, re-elected—Eighth District

R. R. Calvert, Lafayette, re-elected—Ninth District

Mahlon F. Miller, Fort Wayne, re-elected—Twelfth District

Reports of Officers

DR. IRVIN W. WILKENS, treasurer, reported that he had deposited \$30,000.00 of AMEF funds in three building and loan associations, \$10,000.00 in each, on which the interest is four percent, and which is available at any time the Association might wish to withdraw it.

In the absence of Dr. Guy A. Owsley, president, the chairman made some comments on his behalf relative to the recent AMA meeting:

(1) The fact was pointed up that the Association must become much more active at the national level.

Clinically Proven

in more than 750 published clinical studies
and over six years of clinical use

Outstandingly Safe and Effective

for the tense and
nervous patient



- 1 simple dosage schedule relieves anxiety dependably — without the unknown dangers of “new and different” drugs
- 2 does not produce ataxia, stimulate the appetite or alter sexual function
- 3 no cumulative effects in long-term therapy
- 4 does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- 5 does not muddle the mind or affect normal behavior

Usual dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS®—400 mg. unmarked, coated tablets; and in sustained-release capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

* TRADE-MARK

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / Cranbury, N. J.

CH-4750

(2) Study should be given to forming a political action committee at the state level to guide Association policies and to assist Indiana's AMA delegates.

(3) Delegates should have more active direction from the State Association.

(4) Consideration should be given to paying the expenses of alternate AMA delegates so that more men will be trained in the activities at the AMA level and that future leadership at the national level will be developed.

THE CHAIRMAN: The suggestion has been made, and I believe it will be implemented, that prior to the next interim meeting perhaps it would be advisable to have our delegates meet with say the Executive Committee to outline any objectives that our Association as a State Association might be particularly interested in presenting at the national level. We feel that it should also be spelled out exactly who should lead the delegation and we also feel that there should be some long-range planning in order that our delegates become interested in definite spheres of action at the AMA level, so that they can become authorities in a given field and so that our Association through our delegates will exercise more leadership at the AMA level. . . . I don't believe that this requires action at this time but I'm sure that we must do some long-range planning and develop some operating procedures so that we can compete at a more realistic level as far as national medical politics are concerned.

Report of Delegates to the AMA: Drs. Wendell C. Stover, Harold C. Ochsner and Gordon B. Wilder, AMA delegates, reported on the actions taken by the AMA House of Delegates at the annual convention held at New York, June 25 to 29, 1961. (See Convention Section, September, 1961 Journal for complete report.)

Unfinished Business

1. Building Committee.

a. **DR. RALPH EVERLY**, chairman, reported on the activities of the Building Committee since the last meeting of the Council, saying that it had been necessary to make some revisions in the plans, to keep the total construction cost within the sum authorized by the House of Delegates.

Dr. Everly presented the following resolution, which, on motion of Drs. Paris and Eades, was approved:

RESOLUTION OF BUILDING COMMITTEE

WHEREAS, the Building Committee of Indiana State Medical Association was empowered and directed to secure a site and build a building for said Association; and

WHEREAS, in the performance of said duties the Committee through its architect secured the sealed bids of five (5) reputable contractors in the Indianapolis area, the lowest of whom was Thomas A. Berling & Sons, Inc.; and

WHEREAS, all of said bids far exceeded the stipulated sum for said construction; and

WHEREAS, this Committee, together with the architect, then entered into negotiations with said lowest bidder to endeavor to secure a bid on a building costing less and within the budget of said Committee; and

WHEREAS, modified plans and modified specifications were drafted and submitted to said Thomas A. Berling & Sons, Inc.; and

WHEREAS, said contractor has submitted a bid of \$174,000.00 for General Construction Work

\$ 37,000.00 for Electrical Work

\$ 75,000.00 for Plumbing, heating, ventilating and air conditioning (including exterior sewer work)

and

WHEREAS, this Committee is of the opinion that a contract should be entered into immediately with said Contractor on the above terms, except that the electrical item of \$27,000.00 and the plumbing, heating, ventilating and air conditioning item of \$75,000.00 should be resubmitted to subcontractors, with detailed specifications, and this Association would have the benefit of any reduction in the above sums.

NOW, THEREFORE, BE IT RESOLVED, That this Building Committee of the Indiana State Medical Association should enter into a contract with Thos. A. Berling & Sons, Inc. for \$276,000.00 for general construction, electrical work, plumbing, heating, ventilating and air conditioning of said building, in accordance with the plans and specifications, as now modified by Lennox, Matthews, Simmons and Ford, Inc., and subject to the following:

1. The electrical, plumbing, heating, ventilating, and air conditioning (including exterior sewer work) shall be resubmitted to subcontractors and the Indiana State Medical Association shall be given the benefit of any reduced price under the quoted \$27,000.00 for electrical work and \$75,000.00 for plumbing, heating, ventilating and air conditioning work.

2. Said contract shall be submitted to the Executive Committee and Council of Indiana State Medical Association for their approval and direction before execution.

3. Said contract shall be approved by the attorneys of Indiana State Medical Association for their approval as to form of the terms and conditions before execution.

4. A performance bond shall be purchased by Contractor on terms and conditions which meet the approval of the attorneys for said Association.

5. On approval of the Executive Committee, Council, and Attorneys of said Indiana State Medical Association, the members of this Committee, together with the President or President-elect and Executive Secretary, shall sign said contract for and on behalf of said Indiana State Medical Association.

RALPH V. EVERLY, M.D.

JACK E. SHIELDS, M.D.

R. CASE HAMMOND, M.D.

Building Committee of the Indiana State Medical Association

Dated: July 9, 1961.

b. **DR. DON E. WOOD**, chairman of the Executive Committee, then presented the following resolution which had been prepared and adopted by the Executive Committee:

Trademarked
drugs ...



or “drugs
anonymous”?

In the field of medicine, as almost everywhere else in a free economy, the trademark concept has evolved over the years. As with most human institutions, there are some who may not consider it ideal; but it has brought about three signal benefits:

To the physician it gives assurance of quality in the drugs he prescribes—assurance backed by the biggest asset of the maker, his reputation.

To the manufacturer it gives one of the greatest possible incentives to produce new and better curative agents.

To the pharmacist it gives preparations which he can dispense with confidence.

If trademarks are done away with, a whole new setup must be created:

1. An enormously expanded, expensive system of government quality control.
2. A new system of generic nomenclature which would magically turn out names not only rememberably simple, but also conforming to the principles of complex chemical terminology.
3. Something new to fill the gap left by the elimination of the trademark incentive to produce new and better drugs.

The American system has been pre-eminent in producing and distributing good medicines. Above all it has been successful in creating new advances in therapy. In a dubious effort to provide cheaper medicines by abolishing the trade names upon which the responsible makers stake their reputations, let us beware of sacrificing this success.

*This message is brought to you on behalf of the producers of prescription drugs to help you answer your patients' questions on this current medical topic. For additional information, please write **Pharmaceutical Manufacturers Association**, 1411 K Street, N. W., Washington 5, D. C.*

RESOLUTION OF EXECUTIVE COMMITTEE
OF INDIANA STATE MEDICAL ASSOCIATION

WHEREAS, the Building Committee of Indiana State Medical Association has submitted their resolution of this date in reference to the building of an association headquarters, a copy of which is attached hereto and marked "Exhibit A," and

WHEREAS, this Executive Committee has studied said resolution thoroughly and has reached a conclusion:

NOW, THEREFORE, BE IT RESOLVED, That this Executive Committee does hereby approve, consent to, and direct the Building Committee, the President or President-elect, and the Executive Secretary of Indiana State Medical Association to enter into a contract with Thos. A. Berling & Sons, Inc. in accordance with the terms and conditions set forth in said resolution.

Dated this 8th day of July, 1961.

DONALD E. WOOD, M.D.
Chairman

Attest: Jas. A. Waggener, Secretary

c. The following resolution was then adopted by the Council on motion of Drs. Kintner and Wilder:

RESOLUTION OF COUNCIL OF
INDIANA STATE MEDICAL ASSOCIATION

WHEREAS, the Building Committee of the Indiana State Medical Association has submitted its resolution of this date in reference to the building of an association headquarters, a copy of which resolution is attached hereto and marked "Exhibit A," and

WHEREAS, the Executive Committee, after studying said resolution thoroughly and carefully, has approved it; and

WHEREAS, this Council has likewise studied said resolution and the terms and advisability of entering into such a contract;

NOW, THEREFORE, BE IT RESOLVED, That the Council does hereby approve, consent to, and direct the Building Committee, the President or President-elect, and the Executive Secretary of Indiana State Medical Association to enter into a contract with Thos. A. Berling & Sons, Inc., in accordance with the terms and conditions set forth in said resolution.

Dated this 9th day of July, 1961.

MAURICE E. GLOCK, M.D.
Chairman

H. R. STIMSON, M.D.
B. E. KINTNER, M.D.
V. EARLE WISEMAN, M.D.
I. W. WILKENS, M.D.
EUGENE S. RIFNER, M.D.
E. T. EDWARDS, M.D.
GORDON B. WILDER, M.D.
WILLIAM B. CHALLMAN, M.D.
RALPH T. EVERLY, M.D.
WM. R. TINDALL, M.D.
K. O. NEUMANN, M.D.
JOHN M. PARIS, M.D.
RALPH C. EADES, M.D.
J. M. BLACK, M.D.

2. *Student Loan Fund.* DR. JAMES O. RITCHEY,

chairman of the Subcommittee of the Committee on Student Loan, discussed the United Student Aid Funds, Inc., a national organization which processes loans to Indiana students under the Higher Education Loan Plan.

Seventeen states have expressed a willingness to go into this plan.

The identity of any sum of money that an organization or group puts into this fund is lost. There is no way in which that money is apportioned or will be apportioned for loans to any one group. It is likely, however, that all the money contributed in Indiana will stay in Indiana for disbursement or loans to Indiana students.

The Indiana National Bank probably has made more of these loans than any other bank in Indiana. Interest rate is 6 percent.

When a loan is granted the student gives a note currently for the amount that he borrows, then five months after graduation or after he leaves school he negotiates a new note with the bank at which time it is agreed how much he pays each month until the note is paid off in three years.

The money put into the fund is to guarantee the student's note at the bank.

Dr. Ritchey reported that the general feeling of the subcommittee appointed to study this matter is that the association should not enter into this arrangement for student loans and that the matter probably should be studied further.

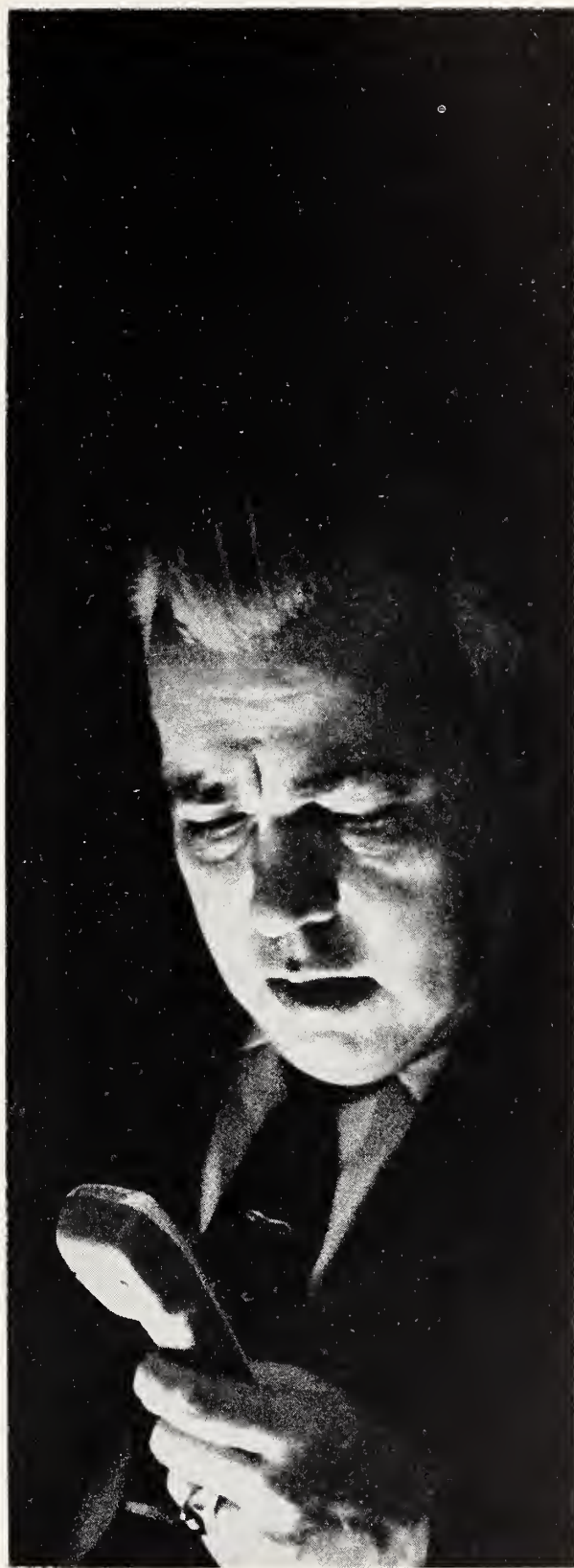
3. *National Science Fair.* DR. RALPH C. EADES, member of the Commission on Medical Education and Licensure, presented a statement of the expenditures made from the \$2,000.00 which was appropriated by the Council "to defray the traveling expenses of only the winners in the biological sciences from each of the 11 regional fairs," which showed that the entire appropriation was spent, not only on the winners in the biological sciences but also on other winners. The secretary asked for approval of the Council in this matter. **On motion of Drs. Paris and Wilder, the Council approved of the manner in which this \$2,000.00 appropriation was spent.**

This also included the new Medical Science group which has been inspired through the interest of organized medicine in Science Fair as an educational activity, both at ISMA as well as AMA levels. Without this financial lift from the ISMA the representatives from Indiana would not have had a complete representation in Kansas City. Indiana won a first place.

4. *Liaison Committee between Council and Blue Shield.* DR. WILLIAM CHALLMAN, chairman, reported on the April meeting of Blue Shield, to which representatives of the various hospitals throughout the state were invited, and at which time the Blue Shield contract was explained: "It was an excellent meeting and I think it did a great deal to cement relationships between Blue Shield and the physicians of Indiana."

5. *Osteopathic matters.* DR. CHALLMAN, chairman of the Council Fact-Finding Committee, called attention to the present AMA policy on osteopathy, as follows:

a. The test now is, does the individual doctor of osteopathy practice osteopathy, or does he in



Day and night— less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl . . .	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

New
ISUPREL®
compound
ELIXIR

Winthrop

LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.

fact practice a method of healing founded on this basis? If he practices osteopathy, he practices a cult of healing, and all voluntary professional associations with him are unethical.

- b. If he bases his practice on the same scientific principles as those adhered to by the American Medical Association, voluntary associations with him should not be deemed unethical.

On motion of Drs. Challman and Kintner, the Council voted to send this information to the secretaries of the component county medical societies.

6. *Editorial Board nominations* were deferred until the next meeting of the Council.

1961 Annual Convention, Indianapolis, October 24, 25 and 26, 1961

1. *Program.* A copy of the scientific and entertainment program, as compiled by the Commission on Convention Arrangements, was distributed to each member of the Council.

2. *Technical and scientific exhibits.* 91 technical and 27 scientific exhibits have been procured for the meeting.

Legislative Matters

DR. DON E. WOOD, co-chairman of the Commission on Legislation, reported on the status of national legislation for the aged.

Membership Matters

Remission of state dues. The Council voted remission of the state dues of a member of the St. Joseph County Medical Society, due to illness and hardship, **on motion of Dr. Kintner and taken by consent.**

New Business

1. MATTERS REFERRED TO COUNCIL BY EXECUTIVE COMMITTEE.

a. *Physicians on Welfare Boards.* The following letter, proposed by Dr. Owsley, to be sent to all Circuit Court judges of Indiana, was read by Dr. Wood, chairman of the Executive Committee:

"The Indiana State Medical Association feels that Senate Bill No. 221, enacted in the recent legislature, is the logical answer to medical care for the aged. As you know, this act is to be administered by the State Welfare Department, and provides for another category defined as the Medically Indigent. In view of this new category, the State Medical Association is of the opinion that a physician appointment to the various Welfare Boards, would be most helpful in the administration of this portion of the act. We are therefore urging your consideration for the appointment of a physician to the Welfare Board, so that medical judgment may be exercised to a better advantage in the evaluation of these cases.

"A copy of this letter is being sent to the President of your local Medical Society, and we are hopeful that a representative member of that group may be given consideration."

Following discussion by Drs. Paris, Wood, Kintner, Edwards, Eades, Rifner, Challman, Black and Holland, **on motion of Drs. Eades and Paris, the Council authorized the sending of a letter of similar content to the county medical societies for their implementation.**

It was taken by consent that the information sent to the county medical societies should include the thinking that Dr. Owsley had in writing this letter, that is, that this is the implementation of the Kerr-Mills Bill under OAA; also, that a physician member of the Welfare Board cannot participate in any benefits of the Board's action. In other words, a doctor on the Board cannot pay himself.

b. *Division of Seventh Councilor District.* Dr. Owsley's proposal to divide the Seventh Councilor District into two separate districts, the additional district to be the Fourteenth Councilor District, for better representation and better liaison in Marion county, was discussed by Drs. Everly, Edwards, Stimson, Eades, Challman, Wilder, Rifner, and Glock (with Dr. Paris in the chair).

On motion of Drs. Glock, Eades and Black, this matter was referred to the Commission on Constitution and Bylaws for further study and presentation to the House of Delegates at the next annual convention.

c. *Blue Cross Hospital Service.* Dr. Wood read the following recommendation of the Executive Committee concerning the letter which was sent by Blue Cross Hospital Service on June 15, 1961, to all hospital administrators:

On June 15, 1961, the Blue Cross Hospital Service addressed a letter to all hospital administrators in the state of Indiana. A copy of this letter is attached.

This letter outlines a plan whereby the physicians of Indiana would be required to complete a form for each patient staying in a hospital over 15 days. A copy of this form is also attached. The penalty for not completing this form is to deny a participating member of Blue Cross Service fulfillment of a contractual arrangement between that patient and Blue Cross (as provided by the availability of benefit days).

This is a request for the Executive Committee of the ISMA to recommend to the Council of the ISMA to in turn recommend to the membership of ISMA that the physicians of Indiana not participate in this program for the following reasons:

1. Such a plan might prevent patients from obtaining their benefits under a contract sold them with quasi-physician-approval.
2. No provision is made for handling patients covered in Indiana who might be in an out-of-state hospital.
3. Physicians cannot always determine the exact time of anticipated discharge.
4. Physicians might be involved in emergency situations and be unable to complete the form.

The ISMA shall inform the Blue Cross office and the physicians of Indiana of its unified opposition to this plan.

The Council of the ISMA recognizes that a small number of physicians may have caused their patients to be confined in hospitals unnecessarily long. The ISMA Council urges Blue Cross Service to present evidence of this nature to it and assures Blue Cross Service that appropriate action will be taken.

Following discussion by Drs. Challman, Edwards, Rifner, Paris, Neumann, Stimson, Black and Holland,

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1961 annual meeting of the Indiana State Medical Association, Oct. 24-26, in Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces which they have produced should fill in the form given below and mail it to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple, Indianapolis. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name _____

Address _____ City _____

Type and number of pieces to be displayed: Photography _____

Sculpture _____ Crafts _____

Painting _____ Other _____

Estimated amount of space required—lineal or square feet _____

Other information _____

on motion of Dr. Black, duly seconded, on a standing vote the Council went on record as endorsing the recommendations of the Executive Committee, that is, that the physicians of Indiana do not participate in the re-confirmation procedure program proposed by Blue Cross.

d. *The following recommendations of the Executive Committee, presented by Dr. Wood, were approved on motion of Drs. Edwards and Challman:*

- (1) That the AMA delegates meet with the Executive Committee prior to the AMA meetings, to better coordinate activities, from both an educational and a political point of view, so as to conform with the policies of the state association for the betterment of all people in the state. Also, that a leader of the AMA delegation be elected, in order to create better communications among the delegates themselves and also with the state association.
- (2) That a brochure be compiled outlining the duties of the delegates and alternate delegates to the AMA and what their responsibilities really are, to avoid confusion.
- (3) That the expenses of alternate delegates be paid by the state association.

e. Employment by the association of a publicity and public relations man on a part-time basis was discussed by Dr. Wood.

2. **GRIEVANCE COMMITTEE.** DR. PHILIP B. REED, chairman, reviewed the AMA Medical Disciplinary Committee report, and the recommendations made by that Committee, which were presented at the New York meeting of the AMA in June, 1961. Dr. Reed quoted from the report: "The results of the study show that by and large adequate medical disciplinary mechanisms do exist and that they are used. The frequency and effectiveness of their use, however, are less impressive. There has been failure in some areas to act promptly, impartially and objectively when the necessity arises."

3. DR. JOHN D. VANNUYS, DEAN, I. U. SCHOOL OF MEDICINE, gave a progress report on the building program at the Medical Center, which includes construction of a new hospital for adults, a \$1,200,000 expansion and remodeling program at Riley Hospital for Children, and a complete remodeling of the old medical school building.

Dr. VanNuys reported that the following research funds had been granted recently to the University:

- a. From the National Heart Institute of Bethesda, \$4,300,000, to be extended over a period of seven years, and to involve the Departments of Medicine, Surgery, Pediatrics, Radiology, Physiology and Biochemistry.
- b. From Wright Patterson Air Force Base for a three-year period, with the Department of Medicine, for a study of space medicine, for the sum of \$680,000.
- c. Approximately \$900,000 for Department of Psychiatry, involving the Carter and Riley Hospitals, for a six-year period.

4. **STATE BOARD OF HEALTH MATTERS.** DR. A. C. OFFUTT, State Health Commissioner, discussed recent developments in the crash program on polio vaccine, for the information of the Council.

State Board of Health members. At the request of Dr. Offutt, the chairman announced that two new medical members of the State Board of Health had been appointed by the Governor: Dr. Earl E. Applegate of Frankfort, and Dr. M. J. Moss of Yorktown. Dr. Richard M. Craig of Fort Wayne was reappointed, at the request of the Board.

5. **COMMISSION ON PUBLIC HEALTH.** DR. EMMETT LAMB, chairman, presented the following matters for the consideration of the Council:

(1) *Polio myelitis vaccine.* The Commission on Public Health recommends:

- a. The use of oral vaccine should not be endorsed at this time.
- b. Further consideration and study should be given the use of oral vaccine and its development.
- c. The statement from the Board of Trustees of the American Medical Association should be sent to each member of the Indiana State Medical Association.

Discussed by Drs. Wood, Kempf, Kintner, Lamb, Stimson and Rifner. Dr. Rifner called attention to the resolution regarding a polio vaccine program which was adopted by the Council at its April 9, 1961, meeting. **In view of this previous resolution, it was taken by consent that no further action was required at this time.**

(2) *Invitation to co-sponsor a statewide Institute with the Central League for Nursing, September 27, 1961, Indianapolis.* Dr. Lamb said this would involve some financial assistance from the State Medical Association.

On motion of Drs. Stimson and Wilder this matter was referred to the Executive Committee for appropriate action, the Council to be notified of the action taken.

(3) *Approval of the Indiana Lions Eye Bank, Inc.* **On motion of Drs. Paris and Edwards the Council approved the Lions Eye Bank,** the purposes of which are to provide free donor materials to eye physicians of Indiana, or elsewhere, if requested, for corneal and vitreous transplants, and to promote teaching and research in the causes and prevention of blindness. The Lions Eye Bank is located in the Department of Ophthalmology, I. U. Medical Center, with the head of that department serving as president of the organization.

6. **TUBERCULOSIS CONTROL.** DR. RICHARD SWAN discussed and DR. GERALD F. KEMPF read the "Recommendations of the Commissions on Public Health and Voluntary Health Agencies to the Council of the Indiana State Medical Association Regarding Tuberculosis," which follows:

In order that the physicians of Indiana may carry on the time honored traditional aims of the medical profession toward the elimination or the reduction to a minimum of communicable diseases, the Commissions on Public Health and Voluntary Health Agencies have under consideration the problem of tuberculosis and have had Council approval for further studies and rec-

ommendations to our members and to the component county societies. The means apparently are presently at hand to reduce this disease to a minimum. The time for more intensive efforts is now, since some or all of the chemotherapeutic and antibiotic agents could lose their effectiveness through the development of resistance by the organisms causing this disease, even though we have high hopes that other even more effective agents will be developed in the future.

Since this disease is known to be caused and spread by the transmission of the organism from those affected to other persons the attack should first be through treatment of the individual patient by the use of chemotherapeutic and antibiotic agents, surgical treatment when indicated and such other methods as advised by the patient's physician as he deems proper for his particular patient and second by examining all intimate household and family contacts by tuberculin testing and chest x-rays in order that all infected persons may also be brought under treatment at the earliest possible stage when recovery is most likely in the shortest time. These two procedures depend on finding the initial case by the awareness of all physicians of the possibility of the disease in the patients in their practices i.e. familiarity with the symptoms and signs and a high index of suspicion, finding cases through chest x-rays, tuberculin testing in the schools and in the physicians' offices and especially on contacts of known cases and of attempting to find the source among contacts of positive reactors as well.

In order to implement the treatment of patients with tuberculosis, we recommend that the Indiana State Medical Association include in its general programs, study courses and the *Journal*, information on the use of the several antibiotic and chemotherapeutic agents, such as isoniazid, streptomycin, paraminosalicylic acid and such other newer agents as have been found effective and newer ones as they are developed, the use of surgical treatment and other approved medical methods in their management. This should include the various combinations of these methods in the treatment of individual patients and the use of isoniazid in primary infections in children. The diagnosis of the disease should also be included in such discussions.

We also recommend that our component district and county societies also be urged to include this subject in their programs.

Since tuberculosis is a communicable disease and immunization of the general population is not yet practicable, and since it is a prolonged disorder that often leads patients to discontinue therapy, to leave their doctors and even seek help from quacks and continue to endanger others, even with complete disregard for their own children and because assistance may be needed in the checking of contacts, especially children, we suggest that the Indiana State Medical Association encourage its members to report their cases of tuberculosis *as soon as the diagnosis is made* and encourage them to make use of their Health Departments and the Tuberculosis Associations whenever their assistance is needed in the control of their patients and in finding new ones among contacts.

Hospitalization should be recommended for those active cases who cannot be treated at home without endangering others and especially for those who fail to follow treatment and disregard reasonable instructions for their protection. In addition, physicians may wish to prescribe hospitalization for other reasons.

We recommend that the Indiana State Board of Health include tuberculosis in the communicable disease summary published monthly in the *Journal* of the Indiana State Medical Association and that this disease be recognized officially as the communicable disease with the highest mortality rate over a five year period.

We recommend that the State Board of Health and its component health districts increase their efforts toward hospitalization of those patients with active tuberculosis who have been recommended for hospitalization because of the presence of children in the home, refusal to follow their physicians instructions, or, who, because of their activities endanger the public health. Better management of the recalcitrant patient problem with closer cooperation of all agencies concerned is highly desirable.

Extension of laboratory services, including sensitivity tests of organisms to chemotherapeutic and antibiotic agents, tests for fungus infections and tests for disease producing capacity might be desirable. Certainly physicians should be more generally cognizant of the services that are available and should be encouraged to use them.

All contacts of patients with tuberculosis should receive tuberculin tests and all positive reactors should have periodical chest x-rays. Positive reactors found in skin testing programs, such as are done in the public schools should have chest x-rays and all family, or household contacts of such reactors should have chest x-rays and skin test.

The Indiana Tuberculosis Association, and its component divisions are to be commended for their efforts in the past and are urged to increase their efforts toward the solution of this problem, in case finding, in aiding or obtaining cooperation of the patients and their contacts with the local physicians, in advising and helping patients with assistance for their families and in aiding local health officers, particularly in those districts that do not have full time facilities.

We recommend that a full committee, including members of these Commissions, the State Board of Health, and the Indiana Tuberculosis Association, coordinate our various efforts in dealing with this problem.

Following discussion by Drs. Offutt, Lamb, Paris, Neumann and Swan, **on motion of Drs. Paris and Eades, the Council voted approval of these recommendations, with an amendment to the last paragraph, which makes this paragraph read:**

"We recommend that a full committee be appointed through the Indiana State Board of Health, including members of these Commissions, the State Board of Health, and the Indiana Tuberculosis Association, to coordinate our various efforts in dealing with this problem."

7. DR. NATHAN SALON, CHAIRMAN OF THE COMMISSION ON AGING, reported on the second White Conference on Aging, held recently, say-

ing that the AMA did a tremendous job, and that this second conference, compared to the first Conference on Aging, was considered very worthwhile by all physicians in attendance.

8. *ELECTION OF TWO MEMBERS TO TRUST COMMITTEE ON INDIANA MEDICAL EDUCATION FOUNDATION.* On motion of Drs. Everly and Paris, Drs. James W. Denny and Roy V. Myers, both of Indianapolis, were re-elected to succeed themselves for three-year terms expiring Oct. 31, 1964.

Membership of this committee is as follows:

Term Expires

Maurice V. Kahler, Indianapolis	-----Oct. 31, 1962
Lawson J. Clark, Indianapolis	-----Oct. 31, 1962
Don E. Wood, Indianapolis	-----Oct. 31, 1963
Roy Geider, Indianapolis	-----Oct. 31, 1963
James W. Denny, Indianapolis	-----Oct. 31, 1964
Roy V. Myers, Indianapolis	-----Oct. 31, 1964

9. *MEMORIAL TO DR. CLEON A. NAFE.* The following resolution, read by Dr. Harold Ochsner, was adopted unanimously:

WHEREAS the Indiana State Medical Association and the American Medical Association have suffered a grievous loss in the recent death of Dr. Cleon A. Nafe, long active in the medical affairs of the nation and the State of Indiana, and

WHEREAS Dr. Nafe had long been active in the Marion County Medical Society, which he had served in many capacities including that of president, and

WHEREAS Dr. Nafe had been a member or chairman of many committees of the Indiana State Medical Association which he had successively served as counselor, chairman of the Council, chairman of the Executive Committee and President, and

WHEREAS Dr. Nafe had served with distinction as a member of the Board of Trustees of the American Medical Association, in which capacity he was a tireless and most effective worker, and

WHEREAS this outstanding surgeon, a man of many talents, which he used for the betterment of his fellow man, who was long active in the civic and medical affairs of the city of Indianapolis in the State of Indiana, will be sorely missed by his community;

NOW THEREFORE, BE IT RESOLVED that the Council of the Indiana State Medical Association memorialize the memory of Dr. Cleon A. Nafe, whose innate honesty and spirit of fair play, whose tireless devotion to the best interest of organized medicine endeared him to all of us, and

BE IT FURTHER RESOLVED that copies of this resolution be published in the *Indiana State Medical Association Journal* and distributed to his surviving family.

The Council stood in silent prayer for a moment in memory of Dr. Nafe.

10. *BLUE SHIELD MEMBER-AT-LARGE.* On motion of Drs. Stimson and Wilder, Dr. James M. Leffel of Indianapolis was nominated to fill the unexpired term ending March, 1963, of Dr. Cleon A. Nafe, deceased, as a member-at-large on the Blue Shield Board of Directors.

11. *THE GENERAL HOSPITAL FACILITY* at Purdue University was discussed briefly by Dr. Neumann.

There being no further business, the Council adjourned to meet again at 3:00 p.m., Monday, Oct. 23, 1961, in Parlors 2 and 3, fourth floor, Columbia Club, Indianapolis. ◀

112th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 23, 24, 25 and 26, 1961

All Time—Eastern Standard Time

Murat Temple

Indianapolis, Indiana

*Complete Program and
Annual Reports on
Following Pages*

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Ind., Oct. 23, 24, 25 and 26, 1961.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, eight delegates; Allen County, five delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jasper-Newton, Jefferson-Switzerland, La-Porte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other 59 county societies, each one delegate; 13 councilors and the ex-presidents, namely George R. Daniels, F. S. Crockett, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Augustus P. Hauss, Alfred Ellison, Paul D. Crimm, William Harry Howard, Walter L. Portteus, Walter U. Kennedy, Elton R. Clarke, M. O. Topping, Kenneth L. Olson and Earl W. Mericle, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Ind. or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 6:00 p.m. Monday, Oct. 23, in the Ballroom, Columbia Club, and again at 1:30 p.m., Thursday, Oct. 26, in the Ballroom, Columbia Club.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Tribute to members of House who have died since the 1960 session.
4. Reading of the minutes of previous meetings.
5. Introduction of guests.
6. Appointment of Reference Committees and assignment of meeting rooms.
7. Unfinished business.
 - (a) Constitutional amendments.
8. Address of president-elect.
9. Report of President of the Woman's Auxiliary.

10. Report of Indiana Chapter Student AMA.
11. Report by president of Blue Shield.
12. Report of executive secretary.
13. Report of treasurer.
14. Report of the chairman of the Council.
15. Reports of councilors.
16. Report of *Journal* Editor.
17. Reports of committees and commissions:

COMMITTEES:

- (1) Executive
- (2) Grievance
- (3) Student Loan
- (4) Medical-Legal Review

COMMISSIONS:

- (1) Convention Arrangements
- (2) Constitution and Bylaws
- (3) Legislation
- (4) Public Information
- (5) Governmental Medical Services
- (6) Public Health
- (7) Voluntary Health Agencies
- (8) Medical Economics and Insurance
- (9) Inter-Professional Relations
- (10) Medical Education and Licensure
- (11) Special Activities
- (12) Aging

18. New Business

- (1) Resolutions from the floor.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire Dec. 31, 1961, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Gordon B. Wilder, Anderson, and Wendell Stover, Boonville; and alternates, Walter L. Portteus, Franklin, and John M. Paris, New Albany.

Delegates from the Third, Sixth, Ninth and Twelfth districts are reminded that the terms of their councilors will expire Oct. 26, 1961, and new councilors should be elected to succeed the following:

Third District: John M. Paris, New Albany

Sixth District: Harry P. Ross, Richmond

Ninth District: K. O. Neumann, Lafayette

Twelfth District: Maurice E. Glock, Fort Wayne

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

HOUSE OF DELEGATES

Indiana State Medical Association

Indianapolis—October 23, 24, 25 and 26, 1961

County and Delegates		County and Delegates	
ADAMS		DECATUR	
Richard K. Parrish, 238 Second St., Decatur		Robert P. Acher, 221 E. Washington St., Greensburg	
ALLEN		DE KALB	
Emory D. Hamilton, 228 Medical Center Bldg., Fort Wayne	J. F. Jackson, Fort Wayne	Charles I. Weirich, Butler	E. E. Rogers, Auburn
Franklin A. Bryan, 512 Medical Center Bldg., Fort Wayne	J. R. Ball, Fort Wayne	DELAWARE-BLACKFORD	
Frederic L. Schoen, 902 Wayne St., Fort Wayne	W. L. Bridges, Fort Wayne	Thomas M. Brown, 412 White River Blvd., Muncie	Charles Alvey, Muncie
Frederic W. Brown, 2521 Fairfield Ave., Fort Wayne	A. J. Haley, Fort Wayne	Glynn Rivers 625 W. Adams St., Muncie	Donald Taylor, Muncie
Eugene F. Senseny, 2902 Fairfield Ave., Fort Wayne	V. C. Moeller, Fort Wayne	Dean Jackson, 401 W. Washington St., Hartford City	Edward Wierzalis, Hartford City
BARTHOLOMEW-BROWN		DUBOIS	
David L. Adler, County Hospital Columbus	Slater Knotts, Columbus	Charles H. Klamer, Metzger Bldg., Jasper	John Barrow, Dale
Robert Seibel, Nashville	Harry McCullough, Columbus	ELKHART	
BENTON		George R. Bloom, 506 S. Second St., Elkhart	Carlos Mendez, Elkhart
Donald L. McKinney, Otterbein		Frederick W. Bigler, 314 S. Fifth St., Goshen	
BOONE		FAYETTE-FRANKLIN	
Clarence G. Kern, 1726 N. Lebanon, Lebanon		G. T. Watterson, 1910 Virginia Avenue, Connersville	
CARROLL		FLOYD	
T. Neal Petry, 111 E. Franklin, Delphi		Donald R. LaFollette, 1000 E. Spring St., New Albany	Nelson A. Wolfe, New Albany
CASS		FOUNTAIN-WARREN	
Earl W. Bailey, 12 Fifth Street, Logansport	Donald K. Winter, Logansport	Peter R. Petrich, 401 S. Perry St., Attica	Lowell R. Stephens, Covington
CLARK		James W. Crain, Williamsport	Carl D. Nelson, West Lebanon
George M. Wolverton, Clarksville	Joel T. Carney, Jeffersonville	FULTON	
CLAY		Charles L. Richardson, 121 West 8th St., Rochester	Dean K. Stinson, Rochester
Charles E. Moon, Center Point		GIBSON	
CLINTON		Virgil McCarty, 113 S. Main St., Princeton	R. E. Weitzel, Princeton
Robert A. Hedgcock, 259 E. Clinton Street, Frankfort	Charles E. Bush, Kirklin	GRANT	
DAVIESS-MARTIN		Robert M. Brown, 522 Marion National Bank Bldg., Marion	
C. Philip Fox, 305 Peoples Bank, Washington	Robert H. Rang, Washington	GREENE	
Emory B. Lett, 408 E. Main Street, Loogootee	Robert Chattin, Loogootee	H. B. Turner, 126 E. Indiana, Bloomfield	Sam Rotman, Jasonville
DEARBORN-OHIO		HAMILTON	
Lowell G. Hunter, 370 Bielby Road, Lawrenceburg	F. A. Streck, Lawrenceburg	John G. Haywood, 120 N. 11th St., Noblesville	Joe R. Lloyd, Noblesville
Gordon S. Fessler, Rising Sun	J. K. Jackson, Aurora		

County and Delegates	Alternates	County and Delegates	Alternates
HANCOCK D. D. Gill, 1001 N. State St., Greenfield	Wayne H. Endicott, Greenfield	Michael Shellhouse, 3811 Washington St., Gary	J. J. Reed, Hobart
HARRISON-CRAWFORD William E. Amy, Corydon N. E. Gobbel, English	Richard Jordan, Corydon Jess Benz, Marengo	J. B. Nicosia, 1802 Columbus Dr., East Chicago J. P. Birdzell, 124 N. Main St., Crown Point Thomas C. Tyrrell, 800 State Line Ave., Calumet City, Ill.	Samuel J. Brady, Gary
HENDRICKS O. T. Scamahorn, Pittsboro	Malcolm Scamahorn, Pittsboro	LA PORTE G. O. Larson, 1110 Indiana, LaPorte T. D. Armstrong, 120 West 9th St., Michigan City	J. C. Richter, LaPorte F. M. Fargher, Michigan City
HENRY William Robertson, Spiceland	John E. Fisher, New Castle	LAWRENCE Howard T. Hammel, Citizens National Bank Bldg., Bedford	William Robinson, Bedford
HOWARD Garvey Bowers, 210 W. Mulberry, Kokomo	Frederick C. Schwartz, Kokomo	MADISON P. T. Lamey, 423 Citizens Bank Bldg., Anderson Gordon B. Wilder, 338 W. Eighth St., Anderson	
HUNTINGTON Richard W. Wagner, 1355 Guilford, Huntington	Carl S. Ray, Warren	MARION (All addresses Indianapolis) Ted Grisell, 5317 E. 16th St., (18) Lester H. Hoyt, Methodist Hospital (7) Francis P. Jones, 4212 E. Michigan (1) Hunter F. Kennedy, 1105 Prospect (3) Harry Pandolfo, 234 E. Southern Ave. (25) Howard S. Williams, 115 E. 16th St. (2) Richard H. Appel, 320 Hume Mansur Bldg. (4) Howard W. Beaver, 8 E. Troy Ave. (3) John O. Butler 234 E. Southern Ave. (25) Irvin Caplin, 1815 N. Capitol Ave. (2) E. K. Stucky, 1349 Madison Ave. (25) Harold Thornton, 301 E. 38th St. (5) John W. Beeler, 712 Hume Mansur Bldg. (4) Floyd A. Boyer, 442 N. Drexel Ave. (1) Irvin W. Wilkens, 1743 Shelby St. (3) Joseph B. Quigley, 817 Hume Mansur Bldg. (4) William N. Ellis, 1402 N. Olney (1) Robert A. Garrett, I. U. Medical Center (7)	
JACKSON Jack Shields, Brownstown	William Scharbrough, Ewing		Paul Des Jean Rex Joseph Kenneth Kohlstaedt Wm. Leffler William Matthews Ray G. Tharpe Harry Aldrich Warren Coggeshall A. D. Dennison Donald R. Hampshire John Hetherington I. J. Kwitny J. Wm. Wright, Jr. Roy A. Geider Raleigh Lingeman Paul Littlefield Loren Martin B. L. Martz
JASPER-NEWTON K. R. Ockerman, 119 W. Harrison St., Rensselaer Roscoe Yegerlehner, 103 N. Second St., Kentland			
JAY William H. Cripe, 302 N. Meridian St., Portland	F. E. Keeling, Portland		
JEFFERSON-SWITZERLAND Francis Prenatt, Madison State Hospital, Madison Antha A. Hamilton, Vevay			
JENNINGS D. W. Matthews, 130 Walnut St., North Vernon	F. D. Ellis, North Vernon		
JOHNSON Robert H. K. Foster, 301 E. Jefferson St., Franklin			
KNOX Virgil C. McMahan, 609 Dubois St., Vincennes	E. T. Edwards, Vincennes		
KOSCIUSKO William J. Cron, 215 S. High St., Warsaw	R. D. Dormire, Warsaw		
LA GRANGE Philip E. Yunker, Howe	Kenneth Lehman, Topeka		
LAKE Philip Rosenbloom, 571 Lincoln, Gary Ray Elledge, 6415 Forest, Hammond Nicholas Egnatz, 820 Highland, Hammond R. N. Bills, 504 Broadway, Gary	J. B. Nicosia, East Chicago George M. Young, Gary F. F. Premuda, Hammond W. A. Nelson, Gary		

County and Delegates	Alternates
James H. Gosman, 2901 N. Meridian (8)	Dennis Nicholas
Earl J. O'Brian, 3041 Lafayette Road (22)	Malcolm Wrege
Wayne Thompson, 5317 E. 16th St. (18)	John M. Young
MARSHALL	
James Kubley, 304 N. Walnut St., Plymouth	L. W. Vore, Plymouth
MIAMI	
R. E. Barnett, 65 N. Miami St., Peru	Lloyd L. Hill, Peru
MONTGOMERY	
J. M. Kirtley, 416 Ben Hur Bldg., Crawfordsville	F. N. Daugherty, Crawfordsville
MORGAN	
R. W. Van Bokkelen, Medical Arts Bldg., Mooresville	Leon Gray, Martinsville
NOBLE	
Robert Bryan, 705 N. State St., Kendallville	J. R. Nash, Albion
ORANGE	
C. X. McCalla, Paoli	B. E. Sugarman, French Lick
OWEN-MONROE	
Dillon Geiger, 300 E. Kirkwood, Bloomington	William Link, Bloomington
Donald Blackwell, 2121 Allison Ave. (24), Indianapolis	M. S. Brown, Spencer
PARKE-VERMILION	
PERRY	
Fred Smith, Jr., 507 Main St., Tell City	Lewis C. Lohoff, Tell City
PIKE	
Milton Omstead, Petersburg	Donald Hall, Petersburg
PORTER	
Ralph C. Eades, 6 Napoleon St., Valparaiso	J. R. Frank, Valparaiso
POSEY	
Frank Oliphant, 701 Mulberry St., Mt. Vernon	John Crist, Mt. Vernon
PULASKI	
William R. Thompson, 111 Monticello, Winamac	E. L. Hollenberg, Winamac
PUTNAM	
V. Earle Wiseman, 239 Hillsdale, Greencastle	D. J. Steele, Greencastle
RANDOLPH	
Lowell W. Painter, 124 E. Franklin St., Winchester	B. D. Wagoner, Union City
RIPLEY	
RUSH	
Frank H. Green, 134 E. Second St., Rushville	
ST. JOSEPH	
R. A. Ganser, 111 S. Race St., Mishawaka	N. D. Sisson, South Bend
David L. Dunlap, 203 J. M. S. Bldg., South Bend	S. R. Phelps, South Bend

County and Delegates	Alternates
W. D. Buchanan, 919 E. Jefferson Blvd., #107, South Bend	W. J. McCraley, South Bend
Merle E. Whitlock, 123 W. Fourth St., Mishawaka	C. F. Martin, Mishawaka
SCOTT	
Marvin L. McClain, 935 First St., Scottsburg	Carl R. Bogardus, Austin
SHELBY	
Paul R. Tindall, 20 N. Pike St., Shelbyville	Wilson L. Dalton, Shelbyville
SPENCER	
Michael O. Monar, 6th and Main Sts., Rockport	John C. Glackman, Rockport
STARKE	
Guy B. Ingwell, Knox	James F. DeNaut, Knox
STEUBEN	
Donald G. Mason, Angola	Don F. Cameron, Angola
SULLIVAN	
Joe E. Dukes, Dugger	
TIPPECANOE	
Ramon B. DuBois, 23 N. 25th St., Lafayette	R. W. Vermilya, Lafayette
Forrest J. Babb, 2106 S. 9th St., Lafayette	
TIPTON	
A. E. Stouder, Kempton	M. B. Gossard, Tipton
VANDERBURGH	
James H. Crawford, 221 Chestnut St., Evansville	
Patrick J. V. Corcoran, 3700 Bellemeade Ave., Evansville	
John H. Sterne, 3700 Bellemeade Ave., Evansville	
R. Case Hammond, 701 Chestnut St., Evansville	
VIGO	
Stuart R. Combs, 3050 Poplar, Terre Haute	A. W. Cavins, Terre Haute
Norman R. Silverman, 1634 S. 7th St., Terre Haute	James V. White, Terre Haute
WABASH	
Robert M. LaSalle, Sr., 645 North Spring St., Wabash	
WARRICK	
Wendell Stover, 125 ½ S. Second St., Boonville	Dan E. Woodson, Boonville
WASHINGTON	
I. E. Huckleberry, 502 West Mulberry St., Salem	H. G. Coleman, Salem
WAYNE-UNION	
Glen Ward Lee, 139 Medical Arts Bldg., Richmond	Tom S. Shields, Richmond
J. F. Lewis, 20 E. Union St. Liberty	C. G. Clarkson, Liberty

County and Delegates	Alternates
WELLS	
Truman E. Caylor, 303 S. Main St., Bluffton	Pierre C. Talbert, Bluffton
WHITE	
Jesse P. Galbreth, Burnettsville	Frank L. Baynes, Wolcott
WHITLEY	
Thomas Hamilton, Columbia City	Jules Heritier, Columbia City

COUNCILORS

- 1st District—William B. Challman, 431 W. Third St., Mount Vernon.
- 2nd District—E. T. Edwards, 34 S. 7th St., Vincennes.
- 3rd District—John M. Paris, 602 E. Spring St., New Albany.
- 4th District—Joseph M. Black, 502 W. Second St., Seymour.
- 5th District—V. Earle Wiseman, 239 Hillsdale Ave., Greencastle.
- 6th District—Harry P. Ross, 220 S. 19th St., Richmond.
- 7th District—Ralph V. Everly, 668 E. 38th St., Indianapolis (5).
- 8th District—Gordon B. Wilder, 338 W. Eighth St., Anderson.
- 9th District—Kenneth O. Neumann, 618 Lafayette Life Bldg., Lafayette.
- 10th District—James P. Vye, 607 Broadway, Gary.
- 11th District—E. S. Rifner, 301 E. Vine St., Van Buren.
- 12th District—Maurice E. Glock, 229 Medical Center Bldg., Fort Wayne.
- 13th District—Burton E. Kintner, 506 S. Second St., Elkhart.

OFFICERS

- President—Guy A. Owsley, 214 N. High St., Hartford City.
- President-elect—Harry R. Stimson, 504 Broadway, Gary.

Chairman, Executive Committee—Don E. Wood, 6325 Guilford, Indianapolis 20.

Member, Executive Committee—Wendell E. Covalt, 2724 N. West St., Muncie.

Chairman of the Council—Maurice E. Glock, 229 Medical Center Bldg., Fort Wayne.

Treasurer—Irvin W. Wilkens, 1743 Shelby St., Indianapolis (3).

Assistant Treasurer—Charles F. Gillespie, 3400 N. Meridian St., Indianapolis (8).

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- Franklin S. Crockett, 424 Littleton St., West Lafayette.
- R. L. Sensenich, 128 S. Scott St., South Bend.
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- Karl R. Ruddell, 3202 N. Meridian St., Indianapolis (8).
- M. A. Austin, 3900 Washington Ave., Evansville.
- A. P. Hauss, 212 Elsby Bldg., New Albany.
- Paul D. Crimm, Boehne Hospital, Evansville.
- Wm. Harry Howard, 5231 Hohman Ave., Hammond.
- Walter L. Portteus, 1551 N. Main St., Franklin.
- Walter U. Kennedy, Union Block, New Castle.
- Elton R. Clarke, 1039 S. Main St., Kokomo.
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- M. C. Topping, 3050 Poplar St., Terre Haute.
- Kenneth L. Olson, 919 E. Jefferson Blvd., Room 207, South Bend.
- Earl W. Mericle, 1633 N. Capitol Ave., Indianapolis 2.

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- E. S. Jones, Hammond.
- Francis L. Land, Fort Wayne
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- Wendell C. Stover, Boonville

Reference Committees—1961

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- Norman Silverman, Terre Haute (Vigo) chairman.
- Truman E. Caylor, Bluffton (Wells).
- A. E. Stouder, Kempton (Tipton).
- R. Case Hammond, Evansville (Vanderburgh).
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- Frank H. Green, Rushville (Rush) chairman.
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- R. N. Bills, Gary (Lake)
- Robert S. McElroy, Princeton (Gibson).
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- Philip Todd Holland, Bloomington (Owen-Monroe).
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- Patrick Corcoran, Evansville (Vanderburgh).

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- Glen Ward Lee, Richmond (Wayne-Union).

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- William R. Thompson, Winamac (Pulaski).
- Guy B. Ingwell, Knox (Starke).
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T. D. Armstrong, Michigan City (LaPorte).
Clarence G. Kern, Lebanon (Boone).
Joseph M. Black, Seymour (Jackson).

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Thomas M. Brown, Muncie (Delaware-Blackford).
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VIGO

George C. Congleton, Terre Haute

WAYNE-UNION

Hubert E. Allen, Richmond

1960-1961

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Guy A. Owsley, M.D.

President

Indiana State Medical Association

1960-61



HARRY R. STIMSON, M.D.
President-Elect
Gary



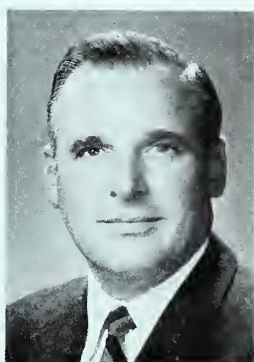
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Treasurer
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JAMES A. WAGGENER
Executive Secretary
Indianapolis



MAURICE E. GLOCK, M.D.
Chairman of Council
Fort Wayne



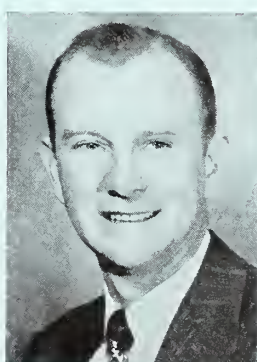
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Muncie



MRS. BURTON E. KINTNER
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Associate Editor
Evansville



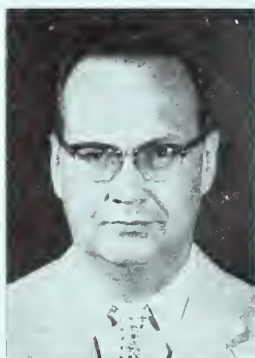
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M.D.
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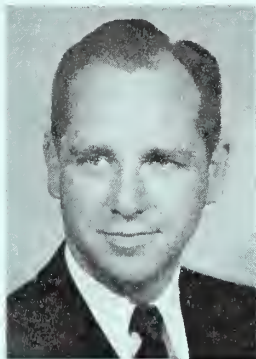
Surgery

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PIERRE C. TALBERT, M.D.
Bluffton

VICE-CHAIRMEN



RICHARD DAVIS, M.D.
Marion

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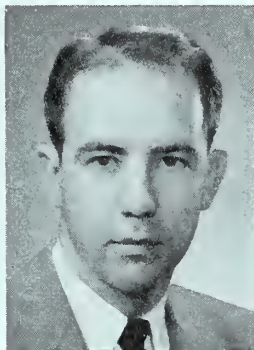
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STEPHEN L. JOHNSON, M.D.
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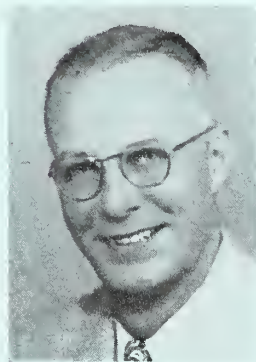


CHARLES E. JACKSON, M.D.
Bluffton

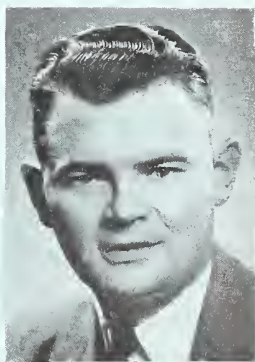
Ophthalmology and Otolaryngology



M. P. CUTHBERT, M.D.
Indianapolis



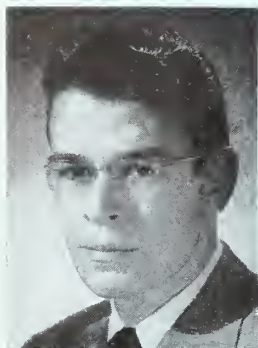
JOHN R. SWAN, M.D.
Indianapolis



M. R. HARDING, M.D.
Indianapolis

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PAUL A. LITTLEFIELD, M.D.
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Vincennes

Obstetrics and Gynecology



JOHN F. SPAHR, JR., M.D.
Indianapolis



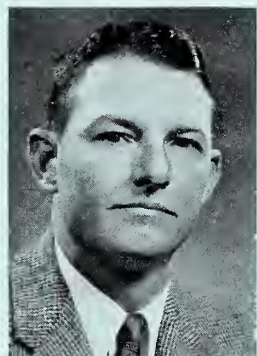
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GEORGE PORTER, M.D.
Richmond

Radiology

CHAIRMEN



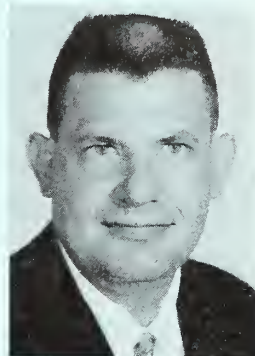
C. A. STAYTON, JR., M.D.
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VICE-CHAIRMEN



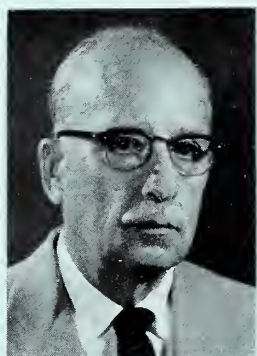
JOHN BEELER, M.D.
Indianapolis

SECRETARIES



DAVID E. WHEELER, M.D.
Indianapolis

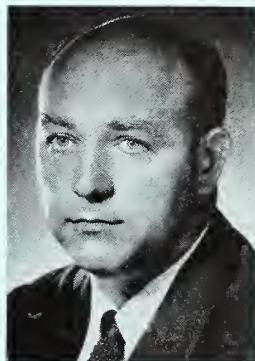
Public Health and Preventive Medicine



PAUL H. MARTIN, M.D.
Elkhart



ARNOLD W. BROCKMOLE, M.D.
Evansville



WILSON L. DALTON
Shelbyville

Schedule of Events

112th Annual Convention

Indiana State Medical Association

Murat Temple, Indianapolis, Indiana

October 23, 24, 25 and 26, 1961

All Events on Eastern Standard Time

(The entire scientific program of the 112th annual convention of the Indiana State Medical Association is approved for Category No. II credit by the Indiana Academy of General Practice for its members. Instructional Courses are approved for Category No. I credit.)

Monday Morning, October 23

- 8:30 a.m. Annual golf tournament, Meridian Hills Country Club. (North on Meridian to 71st St.; west on 71st to Spring Mill Road; south on Spring Mill Road to entrance of club.)
- 11:00 a.m. Annual trap-skeet shoot, Indiana Gun Club.

Monday Noon, October 23

- Noon Executive Committee meeting, Fairbanks Room, fourth floor, Columbia Club.

Monday Afternoon, October 23

- 3:00 p.m. Council meeting, parlors B and C, fourth floor Columbia Club.
- 10:00 a.m. &
2:00 p.m. Bowling tournament, Miracle Lanes, 6125 East 38th Street. Physicians and/or wives.

Monday Evening, October 23

- 6:00 p.m. Meeting of House of Delegates, Ballroom, Columbia Club.

Tuesday Morning, October 24

- 7:30 a.m. Breakfast meeting of the Council, Harrison Room, Columbia Club.
- 8:30 a.m. Registration starts, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.
- 9:00 a.m. Reference Committees meet. Basement dining room, Murat Temple.
- 8:30 a.m. Opening of technical and scientific exhibits, lounge room, Murat Temple.
- 8:30 to 10 a.m. Time allowed to view technical and scientific exhibits.

GENERAL MEETING

(Murat Theater)

- 10:00 a.m. Call to order by Guy A. Owsley, M.D., Hartford City, president, Indiana State Medical Association.
- James M. Leffel, M.D., chairman of Commission on Convention Arrangements, presiding.
- 10 to 12 noon SYMPOSIUM ON HYPERTENSION
Diagnostic Technics in the Evaluation of Reversible Renal Hypertension

Introduction: JOHN B. HICKAM, M.D., Indianapolis.

Recognition and Clinical Importance of Reversible Renal Hypertension

I. *Demonstration of Pressor Substance in Renovascular Hypertension*

WALTER E. JUDSON, M.D., Indianapolis. (15 min.)

II. *Diagnostic and Prognostic Value of Differential Renal Function Studies in Renovascular Hypertension*

HARRIET P. DUSTAN, M.D., Cleveland. (15 min.)

III. *The Radioisotope Renogram in Renovascular Hypertension*

CHESTER E. WINTER, M.D., Columbus, Ohio. (15 min.)

IV. *Renal Angiography in the Evaluation of Renovascular Disease*

GEORGE C. MORRIS, Jr., M.D., Houston, Texas. (15 min.)

Moderator: HICKAM

Panel: JUDSON, DUSTAN, WINTER, MORRIS



JOHN B. HICKAM, M.D.
Indianapolis
Professor of Medicine; Chairman, Dept. of Medicine, Indiana University School of Medicine; Specialist in Internal Medicine; M.D. from Harvard University School of Medicine, 1940.



WALTER E. JUDSON, M.D.
Indianapolis
Associate professor of Medicine, Indiana Univ. School of Medicine; Specialist in Cardiovascular Diseases; M.D. from Johns Hopkins Univ. School of Medicine, 1942.

Tuesday Noon, October 24

- 12 noon Luncheon meeting of past presidents of the Indiana State Medical Association, Veterans Room, Athenaeum.
- 12 noon Editorial Board luncheon meeting, Directors' Room, Athenaeum.
- 12 noon International College of Surgeons luncheon meeting, Ladies Parlors, (large room), Athenaeum.

HARRIET P. DUSTAN, M.D.
Cleveland, Ohio
Staff, Research Division, Cleveland Clinic; M.D. from University of Vermont College of Medicine, 1944.



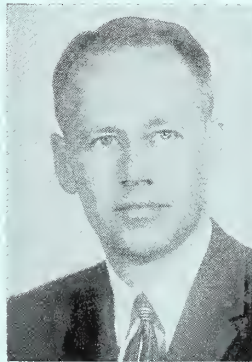
Tuesday Afternoon, October 24

- 12 to 2 p.m. Time allowed to view technical and scientific exhibits.

GENERAL MEETING

(Murat Theater)

Guy A. Owsley, M.D., Hartford City, president, Indiana State Medical Association, chairman.



CHESTER C. WINTER, M.D.
Columbus, Ohio
Prof. and Director, Division of Urology, Ohio State University Health Center; Consultant, Children's Hospital, Columbus, Veterans Hospital, Dayton, Wright Patterson Airforce Base, Dayton; M.D. from Ohio State Univ. College of Medicine, 1946.

- 2 to 4 p.m. **TREATMENT OF HYPERTENSION**
Introduction: **WALTER E. JUDSON, M. D.**, Indianapolis.
Some Consideration in Anti-hypertensive Therapy

- I. *The Role of Diuretics in the Management of Arterial Hypertension*
WILLIAM HOLLANDER, M.D., Boston. (15 min.)

- II. *Pharmacodynamics and Therapeutic Use of Guanethidine in Arterial Hypertension*
HARRIET P. DUSTAN, M.D., Cleveland. (15 min.)

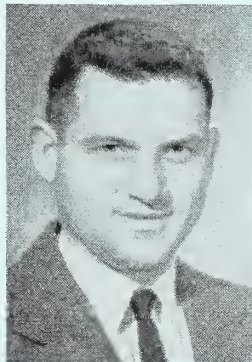
- III. *Surgical Treatment of Renovascular Hypertension*
GEORGE C. MORRIS, Jr., M.D., Houston, Texas. (Motion picture, 30 min.)

Moderator: JUDSON

Panel: HOLLANDER, DUSTAN, MORRIS, WINTER

Summation and concluding remarks:

GEORGE C. MORRIS, M.D.
Houston, Tex.
Assistant Professor of Surgery; Director, Surgical Research Laboratory, Baylor Univ. College of Medicine; M.D. from Univ. of Pennsylvania School of Medicine, 1948.



WILLIAM HOLLANDER, M.D.
Boston, Mass.
Asst. Prof. of Medicine, Boston U. School of Medicine; Spec. in Cardiology; Asso. member visiting Physician and Chief, Hypertensive Clinic, Mass. Memorial Hosps.; M.D. State U. of N.Y., 1949.

SPEAKERS

EUGENE A. STEAD, JR., M.D.
Durham, N.C.
Senior Prof. of Medicine, Duke Univ. School of Medicine; Physician-in-Chief, Duke Hospital; M.D. from Emory Univ. School of Medicine, 1932.



Tuesday Afternoon, October 24

Continued

EUGENE A. STEAD, Jr., M.D.,
Durham, North Carolina.

4 to 5 p.m. Time allowed to view technical and scientific exhibits.



ANDREW L. BANYAI, M.D.
Chicago, Ill.
Clinical Professor of Medicine Emeritus, Marquette University, Milwaukee.

Tuesday Evening, October 24

5:00 to 7:45 p.m. Annual Meeting of The Indiana Chapter of the American College of Chest Physicians, dining room, third floor, Columbia Club.

Cocktails followed by Dinner

PANEL ON THE "Management of the Cardiorespiratory Cripple."

Moderator: **ANDREW L. BANYAI, M.D.,** Chicago.

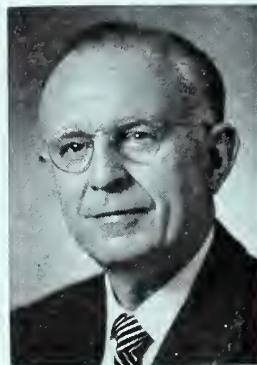
Panel: **JOHN F. BRIGGS, M.D.,** St. Paul, Minn.

EDWIN R. LEVINE, M.D., Chicago.

HERMAN J. MOERSCH, M.D., Rochester, Minn.

LEON UNGER, M.D., Chicago.

JOHN F. BRIGGS, M.D.
St. Paul, Minn.
Associate Professor of Clinical Medicine, University of Minnesota. President-Elect, American College of Chest Physicians.



HERMAN J. MOERSCH, M.D.
Rochester, Minn.
Emeritus Professor of Medicine, Mayo Foundation, University of Minnesota.



LEON UNGER, M.D.
Chicago, Ill.
Associate Professor of Medicine, Northwestern University.



EDWIN R. LEVINE, M.D.
Chicago, Ill.
Assistant Professor of Clinical Medicine, Chicago Medical School.

6:00 p.m. Reception and annual dinner meeting for women physicians, Parlors D and E, fifth floor, Indianapolis Athletic Club. (Dinner at 6:30.)

7:00 p.m. Dinner meeting, SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY, ISMA, and Indiana Academy of Ophthalmology and Otolaryngology, members, wives and guests, Parlor A, fifth floor, Indianapolis Athletic Club.

Speaker: DR. JOSEPH A. McANDREW, Case Institute of Technology and Applied Sciences, Cleveland, Ohio

Subject: *"Exploring Nasal Cavities with Camera and Gun."*

Election of Section officers for 1962

8:00 pm. Fireside Conferences, sponsored by ISMA and Indiana Chapter of American College of Chest Physicians, Ballroom, Columbia Club. (For details see page 1445.)

Wednesday Morning, October 25

7:30 a.m. Breakfast meeting of the Council, Harrison Room, fourth floor, Columbia Club.

8:30 a.m. Registration continues, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

9 to 11 a.m. Instructional courses, Murat Temple.

8:30 to 11 a.m. Time allowed to view technical and scientific exhibits.

GENERAL MEETING

(Murat Theater)

11:00 a.m. Guy A. Owsley, M.D., Hartford City, president, Indiana State Medical Association, chairman.

Speaker: F. J. L. BLASINGAME, M.D., Chicago, Executive Vice President, American Medical Association.

Wednesday Noon, October 25

12 noon Joint luncheon meeting of SECTION ON RADIOLOGY and Indiana Roentgen Society, East Room, Athenaeum.

Speaker: DAVID G. PUGH, M.D., Rochester, Minnesota.

Subject: *"Skeletal Changes Caused by Renal Disease."*

Election of Section officers for 1962

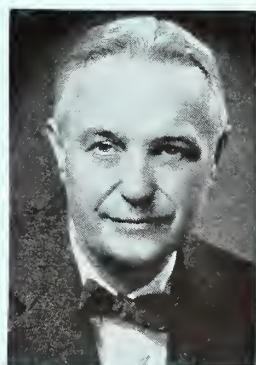
SPEAKERS



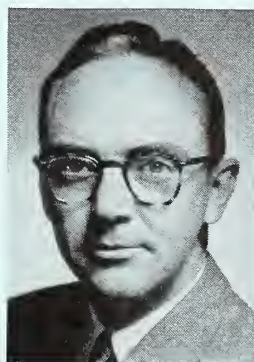
F. J. L. BLASINGAME, M.D.
Chicago, Ill.
Executive vice president, American Medical Association; M.D. from University of Texas, 1932.



DAVID G. PUGH, M.D.
Rochester, Minn.
Consultant in Diagnostic Roentgenology, Mayo Clinic; M.D. from Indiana Univ. School of Medicine, 1932.



JOHN B. HAZARD, M.D.
Cleveland, Ohio
Vice president, International Academy of Pathology; Chairman, Division of Pathology, Cleveland Clinic Foundation; Associate in Pathology, Western Reserve Univ. School of Medicine; M.D. from Harvard Medical School, 1930.



KENNETH W. WARREN, M.D.
Boston, Mass.
Consultant surgeon, Lahey Clinic, Boston; Specialist in General Surgery; M.D. from Temple University School of Medicine, 1938.

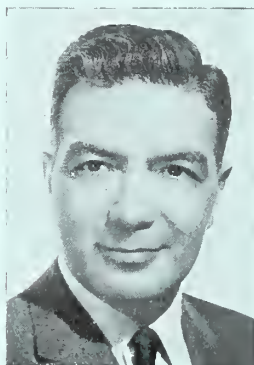
SPEAKERS



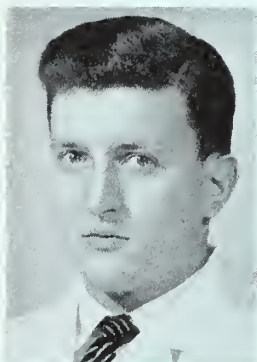
RUDOLPH J. NOER, M.D.
Louisville, Ky.
Professor and Chairman, Department of Surgery, Univ. of Louisville School of Medicine; Editor, Journal of Trauma, Chairman, National Cooperative Surgical Adjuvant Chemotherapy Project; M.D. from Univ. of Pennsylvania School of Medicine, 1927.

HARRIS B. SHUMACKER, JR., M.D.
Indianapolis

Professor and Chairman, Department of Surgery, Indiana Univ. Medical Center; Representative to Advisory Board for Medical Specialties; M.D. from Johns Hopkins Univ. School of Medicine, 1932.



CHARLES B. CLAYMAN, M.D.
Chicago, Ill.
Specialist in Gastroenterology; On teaching staff, Univ. of Chicago School of Medicine; M.D. from Indiana University School of Medicine, 1949.



Wednesday Noon, October 25

- Continued*
- 12 noon Indiana Association of Pathologists luncheon meeting, Ladies Parlors (large room), Athenaeum.
Speaker: JOHN B. HAZARD, M.D., Cleveland.
Subject: "Autoantibodies in Thyroid Disease—Present Status."
- 12 noon Phi Chi luncheon, Fraternity Room, Athenaeum.
- 1:00 p.m. Flying Physicians Association, Indiana Chapter, meeting. Basement Foyer, Murat Temple.
(Not a luncheon meeting.)
- 12:15 p.m. Indiana Society of Internal Medicine luncheon meeting, Harrison Room, Columbia Club.

- 12 noon Phi Rho Sigma luncheon, Veterans Room, Athenaeum.
- 12 noon Phi Beta Pi, luncheon, Blue Room, Athenaeum.
- 12 to 2 p.m. Time allowed to view technical and scientific exhibit.

Wednesday Afternoon, October 25

GENERAL MEETING

(Murat Theater)

Guy A. Owsley, M.D., Hartford City, president, Indiana State Medical Association, chairman.

- 2 to 4 p.m. *Panel discussion: SURGICAL DISEASES OF THE GASTROINTESTINAL TRACT.*

Moderator: KENNETH W. WARREN, M.D., Boston (Surgeon)

Members of the panel:

JOHN B. HAZARD, M.D., Cleveland (Pathologist)

DAVID G. PUGH, M.D., Rochester, Minnesota (Roentgenologist)

RUDOLPH J. NOER, M.D., Louisville (Surgeon)

HARRIS B. SHUMACKER, Jr., M.D., Indianapolis (Surgeon)

CHARLES B. CLAYMAN, M.D., Chicago (Gastroenterologist)

- 4 to 5 p.m. Time allowed to view technical and scientific exhibits.

- 5:15 p.m. Reception for members of Fifty-Year Club, Parlors A and B, Columbia Club.

Chairman: HERMAN M. BAKER, M.D., Evansville.

Wednesday Evening, October 25

- 7:00 p.m. President's reception, Dining Room, third floor, Columbia Club.
- 8:00 p.m. Annual dinner, Ballroom, Columbia Club. (Tarkington Strollers)
Presiding officer, GUY A. OWSLEY, M.D., President, Indiana State Medical Association.
Invocation.
Recognition of Fifty-Year Club members.
Address: GUY A. OWSLEY, M.D., Hartford City, president.
Presentation of plaque to GUY A. OWSLEY, M.D., Hartford City, president 1961, by HARRY R. STIMSON, M.D., Gary, president 1962.
Dance, following dinner.

Thursday Morning, October 26

- 7:30 a.m. Breakfast meeting of Council, Harrison Room, fourth floor, Columbia Club.
8:30 a.m. Registration continues, lounge room, Murat Temple.
8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.
8:30 to 9 a.m. Time allowed to view technical and scientific exhibits.

SECTION MEETINGS

SECTION ON SURGERY

(Candidates Room, Murat Temple)

9 to 11 a.m. *Acute Abdominal Conditions*

(Panel discussion and question-answer period)

Participants:

HARRIS B. SHUMACKER, Jr., M.D.,
Indianapolis

KENNETH W. WARREN, M.D.,
Boston

RUDOLF J. NOER, M.D., Louisville
Election of Section officers for 1962

SECTION ON MEDICINE

(Egyptian Room, Murat Temple)

9:00 a.m. Election of Section officers for 1962

SECTION ON GENERAL PRACTICE

(Egyptian Room, Murat Temple)

9:00 a.m. Panel discussion. Speakers to be announced.
Election of Section officers for 1962

9:00 a.m. Joint meeting of SECTION ON PUBLIC HEALTH AND PREVENTIVE MED-

ICINE and Indiana Health Officers Association, Foyer to Egyptian Room, Murat Temple.

"The Present Status of Injected Polio Vaccine,"

CLYDE G. CULBERTSON, M.D.,
Indianapolis

"The Present Status of Live Polio Vaccines,"

ANTON SCHWARZ, M.D.,
Indianapolis

Election of Section officers for 1962.

10:00 a.m. SECTION ON OBSTETRICS AND GYNECOLOGY

(Egyptian Room, Murat Temple)

Business Meeting

Election of Section officers for 1962.

11 to 12 Time allowed to view technical and scientific exhibits.

11:00 a.m. Organization meetings of 1961-62 commission and committee members of the Indiana State Medical Association, Parlors A, B, and C, Columbia Club

Thursday Noon, October 26

12 noon American College of Surgeons, Indiana Chapter, luncheon meeting, Blue Room, Aethnaeum.

Thursday Afternoon, October 26

1:30 p.m. Final meeting of House of Delegates, Ballroom, Columbia Club.

Meetings of Council and Executive Committee immediately following adjournment of House of Delegates.

Bowling Tournament

(ABC Sanctioned)

For Doctor and/or Wife

Monday, October 23 at

Miracle Lanes, 6125 East 38th St., Indianapolis

Prizes for Handicap and Actual Scores

Entry Fee \$2.00 per event (Bowling fee included)

ENTRY BLANK

Name

Address

		Events	Time	
			10am	3pm
Women	Singles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Doubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Singles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men	Doubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mixed Doubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mail to: Dr. or Mrs. Glen V. Ryan
3168 E. Fall Creek Parkway, North Drive
Indianapolis, Indiana

Bowling Committee: Dr. and Mrs. Howard S. Williams Jr., Dr. and Mrs. Ottis N. Olvey,
Dr. and Mrs. Glen V. Ryan, Co-chairmen.

1961 Instructional Courses

ISMA Annual Convention—Indianapolis—Murat Temple

Order your tickets now!!

The schedule of classes for the 1961 Instructional Courses, offered as a special feature of the Annual Convention of the Indiana State Medical Association at Indianapolis, is published below. Classes will be held on Wednesday morning, Oct. 25, 1961, from 9:00 to 11:00.

Instructional courses are approved for Category No. 1 credit by the Indiana Academy of General Practice for its members.

Admission to each class will be by ticket. Order now!! Courses will not conflict with the general scientific program.

Make your check payable to the Indiana State Medical Association. Cost for each course will be \$3.00, or \$5.00 for two courses; select your classes.

Wednesday, October 25, 1961

CLASS NUMBER

- | | | |
|---|-------------|---|
| 1 | 9:00-10:00 | <i>Cerebro-Vascular Accidents—Management and Rehabilitation</i>
Ralph O. Smith, M.D., Vincennes
Edward T. Edwards, Jr., M.D., Vincennes |
| 2 | 9:00-10:00 | <i>Pre-eclampsia—Management and Pathophysiology</i>
David A. Bickel, M.D., South Bend
Carl S. Culbertson, M.D., South Bend |
| 3 | 9:00- 9:30 | <i>Traumatic Injury to Joints of Long Bones</i>
M. C. Topping, M.D., Terre Haute |
| 4 | 9:30-10:00 | <i>Common Allergic Diseases—Diagnosis and Treatment</i>
Donald J. White, M.D., Indianapolis |
| 5 | 10:00-11:00 | <i>Medical and Surgical Problems in Peptic Ulcer</i>
David G. Pietz, M.D., Bluffton
Donald W. Meier, M.D., Bluffton |
| 6 | 10:00-10:30 | <i>Neonatal Emergencies</i>
Wallace E. Bash, M.D., Fort Wayne |
| 7 | 10:00-10:30 | <i>Electrolyte Considerations in Management of Heart Failure</i>
A. N. Ferguson, M.D., Fort Wayne |
| 8 | 10:30-11:00 | <i>Diagnosis and Care of Fungus Diseases of Skin</i>
L. Edward Gaul, M.D., Evansville |
| 9 | 10:30-11:00 | <i>Prevention of Complications Following Vein Stripping</i>
Russell W. Lamb, M.D., Indianapolis |

APPLICATION BLANK

Instructional Course Committee
Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis 4, Indiana

Enclosed find check for \$_____. Please reserve tickets for me for the following Instructional Courses:

Classes, \$3.00 each; two for \$5.00.

Wednesday, October 25, 1961

Class No. 1 _____ (9:00 to 10:00)	Class No. 6 _____ (10:00 to 10:30)
Class No. 2 _____ (9:00 to 10:00)	Class No. 7 _____ (10:00 to 10:30)
Class No. 3 _____ (9:00 to 9:30)	Class No. 8 _____ (10:30 to 11:00)
Class No. 4 _____ (9:30 to 10:00)	Class No. 9 _____ (10:30 to 11:00)
Class No. 5 _____ (10:00 to 11:00)	

I will pick up my tickets at the Registration Desk at the convention.

Signed _____, M.D.

Address _____

Next year please include classes on these topics _____

Convention Arrangements Committees

GENERAL CONVENTION ARRANGEMENTS:

James M. Leffel, Indianapolis, chairman; Ray Tharpe, Indianapolis, vice-chairman; Robert F. Harris, Noblesville, secretary; Ray H. Burnikel, Evansville; Irvin H. Scott, Sullivan; Jesse Benz, Marengo; Robert O. Zink, Madison; Jack G. Weinbaum, Terre Haute; John Mader, Richmond; Howard E. Hill, Muncie; Peter Stecy, Whiting; Max R. Long, Marion; Donald G. Mason, Angola; Bernard E. Edwards, South Bend; Edward B. Smith, Indianapolis.

GOLF: J. M. McIntyre, Indianapolis, chairman.

TRAP-SKEET SHOOT: Charles W. Cure, Indianapolis, chairman.

BOWLING: Glen V. Ryan, Indianapolis, chairman.

RECEPTION: John W. Hendricks, Indianapolis, chairman.

PUBLICITY: Harry Pandolfo, Indianapolis, chairman.

WOMEN PHYSICIANS: Martha C. Souther, Indianapolis, chairman.

WOMEN'S ENTERTAINMENT: Mrs. Archie E. Brown, Indianapolis, chairman.

FIFTY-YEAR CLUB RECEPTION: Herman M. Baker, Evansville, chairman.

Hotels in Indianapolis

CLAYPOOL HOTEL, Washington & Illinois Street: 600 Rooms. Rates—Single \$8.00 to \$12.00; Double \$10.50 to \$15.00; Twin Bed Rooms \$12.50 to \$18.00; Suites \$20.00 to \$34.00.

CONTINENTAL HOTEL, 410 N. Meridian St.: 100 Rooms. Rates—Single \$6.50 up; Double \$8.00 up; Twin Bed Rooms \$12.00 up; Suites \$18.00 up.

DRAKE MOTOR HOTEL, 1415 N. Pennsylvania St.: 60 Rooms. Rates—Single \$7.00 to \$10.00; Double \$9.50 to \$13.00; Twin Bed Rooms \$10.00 to \$13.50; Suites \$18.00.

GRAYLYNN HOTEL, 1043 N. Pennsylvania St.: 75 Rooms. Rates—Single \$7.50 up; Double \$9.00 up; Twin Bed Rooms \$12.00 up; Suites \$13.00 up.

HARRISON HOTEL, 51 N. Capitol Ave.: 200 Rooms. Rates—Single \$6.75 and up; Double \$9.25 and up; Twin Bed Rooms \$12.50 and up; Suites \$20.00 and up.

MAROTT HOTEL, 2625 N. Meridian St.: 350 Rooms. Rates—Single \$8.50 to \$15.00; Double \$11.50 to \$16.00; Twin Bed Rooms \$14.00 to \$19.00; One Bed Room Suite \$22.00 to \$27.00; Two Bed Room Suite \$35.00.

MERIDIAN PLAZA MOTOR HOTEL, 750 N. Meridian St.: 200 Rooms. Rates—Single \$5.00 to \$10.00; Double \$7.00 to \$13.00; Twin Bed Rooms \$8.50 to \$13.00; Suites \$15.00 to \$20.00.

MOHAWK HOTEL, 5855 E. Washington St.: 83 Rooms. Rates—Single \$6.50 and \$7.50; Double \$9.00 and \$11.00; Twin Bed Rooms \$10.00 and \$11.00.

PENNSYLVANIA HOTEL, 947 N. Pennsylvania St.: 60 Rooms. Rates—Single \$6.00; Double \$8.00; Twin Bed Rooms, \$9.00.

SEVERIN HOTEL, 201 S. Illinois St.: 400 Rooms. Rates—Single \$5.50 up; Double \$8.50 up; Twin Bed Rooms \$12.00 up; Suites \$27.00.

SHEFFIELD INN, 958 N. Pennsylvania St.: 125 Rooms. Rates—Single \$5.50 up; Double \$8.50 up; Twin Bed Rooms \$9.00 up.

SHERATON-LINCOLN HOTEL, 117 W. Washington St.: 400 Rooms. Rates—Single \$7.00 to \$12.00; Double \$10.50 to \$15.50; Twin Bed Rooms \$13.50 to \$16.00; Suites \$21.50 to \$35.00.

WARREN HOTEL, 123 S. Illinois St.: 250 Rooms. Rates—Single \$6.50 and up; Double \$9.00 and up; Twin Bed Rooms \$12.50 and up; Suites \$25.00 and up.

WASHINGTON HOTEL, 34 E. Washington St.: 300 Rooms. Rates—Single \$7.00 to \$11.00; Double \$8.50 to \$12.00; Twin Bed Rooms \$12.00 to \$20.00; Suites \$17.50 to \$55.00.

NOTE: Arrangements for the following private club facilities may be made only through members.

COLUMBIA CLUB, Monument Circle: 130 Rooms. Rates—Single \$7.00 to \$10.00; Double \$9.00 to \$10.50; Twin Bed Rooms \$9.00 to \$13.50; Suites \$25.00 to \$29.00.

INDIANAPOLIS ATHLETIC CLUB, 350 N. Meridian St.: 135 Rooms. Rates—Single \$5.75 to \$7.25; Double \$10.75; Twin Bed Rooms \$12.00; Suites \$17.50 up.

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1961 annual meeting of the Indiana State Medical Association, Oct. 24-26, in Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces which they have produced should fill in the form given below and mail it to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple, Indianapolis. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name _____

Address _____ City _____

Type and number of pieces to be displayed: Photography _____

Sculpture _____ Crafts _____

Painting _____ Other _____

Estimated amount of space required—lineal or square feet _____

Other information _____

Auxiliary Program

Mrs. Archie E. Brown, General Chairman

Monday, October 23

4:00 to 7:00 p.m. Registration, third floor, Columbia Club.

Pick up reserved tickets for dinner.

Deadline for reservations—Saturday, October 21.

6:00 to 7:00 p.m. Social Hour—Cocktails available.

7:00 p.m. "Past Presidents' Jamboree" dinner in honor of former presidents of the Woman's Auxiliary to the Indiana State Medical Association, Columbian Room, third floor, Columbia Club.

Mrs. Burton E. Kintner, Elkhart, president, presiding.

Program:

Speaker: FRANK WOOLLEY, A. M. A.

Subject: *"What Will Your Husband Be Doing Tomorrow?"*

"Broadway Review."

Tuesday, October 24

8:30 a.m. Registration, lounge room, Murat Temple.
Planned tours available, 10:00 to 12 noon.

1:30 to 4:00 p.m. Card party for the benefit of women's lounge, ISMA building, Parlors A, B and C, fourth floor, Columbia Club.

Wednesday, October 25

8:30 a.m. Registration continues, lounge room, Murat Temple.

9:00 a.m. Coffee Hour, Parlors A, B and C, fourth floor, Columbia Club.

10:00 a.m. Board meeting, Parlors A, B and C, fourth floor, Columbia Club. Members and guests welcome.

12:00 to 1:00 p.m. Social Hour — Cocktails available, Ballroom, Columbia Club.

1:00 p.m. "She Walks in Beauty with Wasson's"—Luncheon and Style Show, Ballroom, Columbia Club.

7:00 p.m. I. S. M. A. President's reception, Dining Room, third floor, Columbia Club.

8:00 p.m. Annual dinner in conjunction with the Indiana State Medical Association, Ballroom, Columbia Club.

Dancing, following dinner.

Thursday, October 26

8:30 a.m. Registration continues, lounge room, Murat Temple.

Open day for shopping or visiting.

WOMAN'S AUXILIARY

Order Your Tickets Now

Your Reservations!

Please send in NOW!

Mrs. David Hadley, Reservations Chairman
5601 North Pennsylvania Street
Indianapolis 20, Indiana

Enclosed find my check payable to the Woman's Medical Auxiliary for:

- (1) \$4.50 for Monday dinner.
- (2) \$3.00 for Wednesday luncheon
- (3) \$1.00 for card party for benefit of women's lounge, ISMA building.

I will pick up my tickets at the Columbia Club third floor dining room door.

Signed

Address

Reports of Officers

Executive Secretary

In the annual preparation of this report for the House of Delegates, your secretary is offered the opportunity to reflect upon the past year and to evaluate the progress which has been made. This could be a very long report if I were to attempt to detail the many events which have taken place and the various matters which have crossed the desk of your secretary. It has without a doubt been one of the most active years in the history of your secretary and the entire staff has made every effort to handle expeditiously and efficiently the responsibilities assigned to them.

As you review the reports of the executive committee, the chairman of the council and commissions and committees, I am sure you will agree that much constructive work has been accomplished during the year. The results of the work of the members of the Association are now before you for concurrence or rejection and I am sure that you will find that many recommendations are being made for your consideration which will have a far-reaching effect upon the policy of organized medicine within the state of Indiana.

I want to commend the members of the Association who have participated actively in the work of the committees, commissions and official bodies of your Association. I hope that the members in general can appreciate the sacrifices which these men have made in their conscientious efforts to consider important matters in the interest of their colleagues.

I call your attention to the outstanding work which has been accomplished by some of your commissions and refer in this instance to the Commission on Legislation. The 1961 session of the State Legislature was a most difficult session complicated by the political complexion of the House and Senate and Governor and Lieutenant Governor. The number of bills proposed which would have a bearing on the practice of medicine and the health of the people of this state, grew in numbers over the session two years ago. Your commission met each week with the staff and the attorneys to review all bills and particularly to discuss and decide what action would be taken on legislative matters concerning medicine and health.

In view of the great number of problems which faced this commission, the Association enjoyed a successful year in legislature. The component societies, the auxiliary and individual members of these groups are to be commended for their active participation, their willingness to assist and the effect their grass roots work had in making our efforts so successful.

During this past year, your headquarters office and the commission enjoyed the finest cooperation from the members at large in dealing with their legislative problems. We had more doctors call and write their representatives and senators, and more doctors to visit with their representatives and senators in the halls of this legislature. Our component societies even went a step farther this past year in holding meetings with their representatives and senators to discuss legislative prob-

lems with them. Only with this type of cooperation can our legislative efforts ever be successful. It was most gratifying to note the increased interest and activity on the part of our membership, not only at the state level, but also on national legislative issues. Several representations have been made by your Association before Congress on several matters.

Another committee which has spent considerable time and effort has been the building committee in working out the details for the construction of the headquarters office building. This committee has wisely moved slowly in order to assure the members of your Association they will have the finest installation that can be purchased with the funds available.

Great strides have been made in all fields of endeavor. Our relationships with the voluntary agencies and allied health organizations have reached new plateaus.

I am happy to report to you that the administrative program instituted by your Association at the inception of the Medicare plan . . . on a test basis . . . has been formally adopted by the federal government and will become a nation-wide program as of October 1, 1961. The plan adopted by your Association, through some intensive selling, was one which many said could not work. Indiana medicine has proved they were right . . . that physicians can operate and administer a program such as Medicare effectively, efficiently and economically. The professional committee operating the Medicare program deserves the plaudits of us all for proving that physicians can do the job without government interference. Adoption of our plan by the federal government is a high tribute to the physicians of Indiana.

Your physician placement committee has assisted many physicians in finding locations in Indiana this last year. During the last year, we have handled requests from 184 physicians seeking locations for practice and 45 communities seeking physicians for their communities.

Net membership growth of your Association during the last ten years has exceeded 500. If projections by the economists are right, it is predicted that by 1970 we will have a 33½% increase, or 2,000 additional physicians, in practice in our state at the end of the next ten years.

Present growth in membership, programs and activities has made it necessary to add personnel. During the current year, we have welcomed the addition of Mr. Joseph Palmer to our staff. Joe brings a wealth of experience to your Association, having for many years served as executive secretary of the Marion County Medical Society.

Your headquarters staff have all worked long and arduous hours to complete the work assigned to them. We are indeed fortunate to have such a high percentage of loyal and diligent employees in the headquarters office. We look forward to the coming months and the challenges they are sure to bring.

Your staff again renew their pledge to serve you and their dedication to work continually in the interests of the members of the Association. They hope they will have the opportunity to see an increasingly larger number of the members visit the headquarters office and invite your suggestions as to how they may better serve you.

Your secretary has served this past year as a member of the executive committee of the Medical Society Executive Association; was reelected for the eighth consecutive term as secretary-treasurer of the Conference of Presidents and Officers of State Medical Associations; has participated in many conferences as a panelist, discussant or chairman, and will chair a session on the business management of state medical *Journals* during the annual meeting of The State Journal Conference to be held in Chicago, October 30 and 31.

JAMES A. WAGGENER, *Executive Secretary*

Treasurer

Following is an itemized statement of the securities in the Building Fund, the General Fund and the Medical Defense Fund as of August 1, 1961.

BUILDING FUND	Face Value	Market Value
U. S. Treasury Bonds	\$ 65,000.00	\$ 65,093.50
U. S. Savings Bonds	70,000.00	68,451.00
U. S. Treasury Notes	15,000.00	15,179.00
	<u>\$150,000.00</u>	<u>\$148,723.50</u>

GENERAL FUND		
U. S. Savings Bonds	6,000.00	\$ 5,832.00
U. S. Treasury Bonds	80,000.00	71,520.00
	<u>\$ 86,000.00</u>	<u>\$ 77,382.00</u>

Total Investments Building and General Funds.....	\$236,000.00	\$226,075.50
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U. S. Treasury Bonds and Notes maturity dates:		
1961	62,000.00	62,088.40
1960-65	3,000.00	3,005.10
1962 (Note)	10,000.00	10,024.00
1964 (Note)	5,000.00	5,155.00
1967-72	20,000.00	17,520.00
1978-83	60,000.00	54,000.00
	<u>\$160,000.00</u>	<u>\$151,792.50</u>

U. S. Savings Bonds maturity dates:		
1961	6,000.00	5,952.00
1962	1,000.00	982.00
1963	4,000.00	3,904.00
1964	35,000.00	34,285.00
1966	30,000.00	29,160.00
	<u>\$ 76,000.00</u>	<u>\$ 74,283.00</u>
	<u>\$236,000.00</u>	<u>\$226,075.50</u>

MEDICAL DEFENSE FUND	Face Value	Market Value
U. S. Treasury Bonds	\$ 14,000.00	\$ 14,023.80
U. S. Treasury Bills	3,000.00	3,000.00
U. S. Savings Bonds	9,000.00	8,850.00
Total Medical Defense Fund ...	<u>\$ 26,000.00</u>	<u>\$ 25,873.80</u>

Medical Defense Fund Investment maturity dates:		
U. S. Treasury Bonds		
1960-65	3,000.00	3,005.10
1961	11,000.00	11,018.70
	<u>\$ 14,000.00</u>	<u>\$ 14,023.80</u>

U. S. Savings Bonds		
1961	2,000.00	1,984.00
1962	6,000.00	5,892.00
1964	1,000.00	974.00
	<u>\$ 9,000.00</u>	<u>\$ 8,850.00</u>

U. S. Treasury Bills		
1961	3,000.00	3,000.00
	<u>\$ 26,000.00</u>	<u>\$ 25,873.80</u>

Balance, Aug. 1, 1960		\$ 3,993.25
Receipts:		

Dues: 1960 members	\$ 27.50	
1961 members	4,909.00	

Interest on bonds	592.20	
Matured Treasury Bills	12,000.00	17,528.70

Total Receipts		\$21,521.95
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Disbursements:		
Malpractice fees	\$ 694.92	
Attorneys' salaries	2,790.00	
Paid to Indiana State Medical Association for prior year's obligations.....	1,778.31	

		<u>\$ 5,263.23</u>
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Purchase of U. S. Treasury Bills.....	\$12,000.00	
Less discount on U. S. Treas. Bills....	75.36	

Total Disbursements		\$11,924.64
		<u>\$17,187.87</u>

Balance, August 1, 1961		<u>\$ 4,334.08</u>
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In case we should sell any long-term securities the bank officials inform us that there necessarily would be a loss. Another statement of the value of the long-term securities will be presented at the time of the convention.

Cash balances in the respective funds as shown on the books of the Association as of July 31, 1961 :

General Fund	54,496.35
Medical Defense Fund	4,334.08
Journal Fund	2,055.88
Student Loan Fund	1,329.46
Building Fund	53,202.97

Total cash on hand, July 31, 1961.....	<u>\$115,418.74</u>
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Following is the audit of Wolf and Company, Indianapolis, for the fiscal year ending Sept. 30, 1960.

I. W. WILKENS, MD., *Treasurer*

FINANCIAL REPORT
WOLF AND COMPANY

Certified Public Accountants

The Council
Indiana State Medical Association
Indianapolis, Indiana

We have examined the financial records of Indiana State Medical Association for the year ended September 30, 1960. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying financial statements present fairly the position of Indiana State Medical Association at September 30, 1960, and the results of its operations for the year then ended, in conformity

with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
Wolf and Company
Certified Public Accountants

Indianapolis, Indiana
November 1, 1960

INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana

Exhibit A

STATEMENT OF FUNDS

September 30, 1960

ASSETS

General fund:			
Cash	52,526.04		
Note receivable	1,472.61		
Inventory—tape recorder	271.64		
Deposits with postmaster	635.62		
Prepaid expenses	2,475.88		
Accrued interest receivable	2,768.99		
Due from medical defense fund	1,778.31		
Due from student loan fund	5,101.29	6,879.60	
<hr/>			
Reimbursement due for Medicare expenses ...	2,750.35		
Investments, at cost, less amortization (Note):			
U. S. Treasury bonds.	145,544.39		
U. S. Treasury bills.	43,369.40		
U. S. Treasury notes.	15,000.00		
U. S. Savings bonds..	76,000.00		
	279,913.79		
Less accumulated amortization	341.28	279,572.51	
<hr/>			
Office furniture and equipment			
General office	17,285.27		
Medicare office	4,437.52		
	21,722.79		
Less accumulated depreciation	7,185.75	14,537.04	363,890.28
<hr/>			
The Journal:			
Cash	236.03		
Accounts receivable			
Advertising	10,441.78		
Other	221.80	10,663.58	
Due from general fund	14,439.35		
Postal deposits	203.09	25,542.05	
<hr/>			
Medical defense fund:			
Cash	3,312.08		
Accrued interest receivable	118.60		
Investments, at cost, less amortization:			
U. S. Treasury bonds.	14,235.94		
U. S. Treasury bills .	2,981.10		
U. S. Savings bonds.	9,000.00		
	26,217.04		

Less accumulated amortization	184.69	26,032.35	29,463.03
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Student loan fund:

Cash	2,065.23		
Notes receivable	18,524.95	20,590.18	
			439,485.54

Note:

Investments in U. S. Treasury securities aggregating \$150,000.00 have been allocated to the building fund.

LIABILITIES

General fund:

Liabilities:

Accounts payable	2,798.54		
Accrued payroll taxes	111.09		
Due American Medical Education Fund			
	36,225.00		
Due The Journal	14,439.35		
Pledged to building fund.....	18,075.00		
Unrealized convention income ..	11,872.50		
Dues collected in advance	27,928.00		
Deposits on tape recordings....	270.50		
Amount due officer	58.79		
	111,778.77		
Fund surplus (Exhibit B).....	252,111.51		
			363,890.28

The Journal:

Liabilities:

Accounts payable	304.31		
Prepaid professional cards.....	2,228.28		
	2,532.59		
Fund surplus (Exhibit B).....	23,009.46		
			25,542.05

Medical defense fund:

Due to the general fund	1,778.31		
Fund surplus (Exhibit B)	27,684.72		
			29,463.03

Student loan fund:

Due to the general fund.....	5,101.29		
Fund surplus (Exhibit B).....	15,488.89	20,590.18	
			439,485.54

Exhibit B

STATEMENT OF FUND SURPLUS

For the Year Ended September 30, 1960

General fund:

Balance, September 30, 1959.....	236,675.09		
Excess of revenues over expenditures (Exhibit C)	15,436.42		
Balance, September 30, 1960.....	252,111.51		
<hr/>			
The Journal:			
Balance, September 30, 1959.....	32,462.92		
Excess of expenditures over revenues (Exhibit D)	9,453.46		
Balance, September 30, 1960.....	23,009.46		

Medical defense fund:

Balance, September 30, 1959.....	29,464.42		
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Excess of expenditures over revenues (Exhibit E)	1,779.70	
Balance, September 30, 1960.....	27,684.72	
Student loan fund:		
Balance, September 30, 1959.....	15,333.17	
Interest earned	145.72	
Gift received	10.00	155.72
Balance, September 30, 1960.....	15,488.89	

Exhibit C

STATEMENT OF REVENUES AND EXPENDITURES

For the Year Ended September 30, 1960

GENERAL FUND

	Actual	Budget	Actual Over (Under*) Budget
Revenues:			
Dues	186,991.25	179,320.00	7,671.25
Less dues allocated:			
The Journal	12,231.00	11,268.00	963.00
Medical defense fund..	4,801.25	4,695.00	106.25
American Medical Education fund	36,225.00	35,440.00	785.00
Building fund	18,075.00	17,720.00	355.00
	71,332.25	69,123.00	2,209.25
Dues available for operations	115,659.00	110,197.00	5,462.00
Interest on investments..	9,876.71	8,500.00	1,376.71
Received from AMA	1,158.93	730.00	428.93
Net income—annual meeting	5,315.55	.....	5,315.55
Other income	565.08	.....	565.08
Total revenues	132,575.27	119,427.00	13,148.27
Expenditures:			
Committees and commissions (Schedule C-1) ..	18,734.55	26,150.00	7,415.45*
Officers and council (Schedule C-2)	11,398.41	12,775.00	1,376.59*
Headquarters office (Schedule C-3)	79,532.74	79,375.00	157.74
Woman's Auxiliary	1,596.67	1,000.00	596.67
Employees' retirement fund	5,876.48	5,000.00	876.48
Total expenditures .	117,138.85	124,300.00	7,161.15*
Excess of revenues over expenditures (expenditures over revenues*)	15,436.42	4,873.00*	20,309.42

STATEMENT OF OPERATING EXPENDITURES

For the Year Ended September 30, 1960

Schedule C-1

COMMITTEES AND COMMISSIONS

	Actual	Budget	Actual Over (Under*) Budget
Standing committees:			
Grievance	473.86	450.00	23.86
Student loan	22.55	100.00	77.45*
Medical legal review ...	.....	50.00	50.00*

Commissions:			
Constitution and by-laws	452.30	500.00	47.70*
Interprofessional relations .....	.....	450.00	450.00*
Legislation	5,521.20	6,000.00	478.80*
Public health	739.19	2,500.00	1,760.81*
Public information	6,577.46	7,000.00	422.54*
Special activities	178.13	200.00	21.87*
Voluntary health agencies	800.97	900.00	99.03*
Medical economics and insurance	1,394.74	2,000.00	605.26*
Medical education and licensure	1,130.07	3,000.00	1,869.93*
Building	522.47	2,000.00	1,477.53*
Government medical services	921.61	1,000.00	78.39*
Totals	18,734.55	26,150.00	7,415.45*

Schedule C-2

OFFICERS AND COUNCIL

	Actual	Budget	Actual Over (Under*) Budget
President	631.41	1,500.00	868.59*
President elect	878.72	500.00	378.72
Council chairman	29.60	300.00	270.40*
AMA delegates	3,711.51	4,000.00	288.49*
AMA meetings	1,866.75	2,000.00	133.25*
Treasurer, auditing and bookkeeping	1,550.00	1,125.00	425.00
Council travel	903.90	800.00	103.90
Council meetings	874.97	1,200.00	325.03*
Better Business Bureau...	150.00	150.00	.....
Executive committee:			
Travel	522.26	600.00	77.74*
Meetings	279.29	600.00	320.71*
Totals	11,398.41	12,775.00	1,376.59*

Schedule C-3

HEADQUARTERS OFFICE

	Actual	Budget	Actual Over (Under*) Budget
Salaries	47,383.11	50,000.00	2,616.89*
Supplies	2,354.07	1,600.00	754.07
Telephone and telegraph..	2,944.47	3,000.00	55.53*
Postage	2,374.91	1,600.00	774.91
Printing and stationery...	1,179.52	1,700.00	520.48*
Travel	10,183.79	9,000.00	1,183.79
Rent and electricity.....	4,308.05	4,400.00	91.95*
Organization memberships.	1,376.75	400.00	976.75
Donations	685.00	100.00	585.00
Insurance:			
Hospitalization	835.78	800.00	35.78
Other	1,740.95	550.00	1,190.95
Photographic equipment expenses	25.56	25.00	.56
Extra help	619.12	800.00	180.88*
Payroll taxes	1,027.13	1,100.00	72.87*
Depreciation	1,825.23	1,200.00	625.23
Maintenance—office machines	363.87	.....	363.87
Unallocated	305.43	3,100.00	2,794.57*
Totals	79,532.74	79,375.00	157.74

STATEMENT OF REVENUES AND EXPENDITURES

Exhibit F

For the Year Ended September 30, 1960

Exhibit D

THE JOURNAL

	Actual	Budget	Actual Over (Under*) Budget
Revenues:			
Subscriptions:			
Members	12,231.00	11,268.00	963.00
Nonmembers	451.50	332.00	119.50
Advertising	71,458.23	74,000.00	2,541.77*
Other	1,109.86	1,400.00	290.14*
Total revenues	85,250.59	87,000.00	1,749.41*
Expenditures:			
Salaries (including extra help)	13,582.87	13,720.00	137.13*
Office expense	1,016.74	710.00	306.74
Printing and reprints ..	66,495.71	57,100.00	9,395.71
Engravings	6,334.73	5,120.00	1,214.73
Travel and meetings ...	1,723.16	2,150.00	426.84*
Bulk mailing	1,017.73	1,350.00	332.27*
Other publishing expense	1,139.60	1,790.00	650.40*
Payroll taxes	355.81	340.00	15.81
Employee group insurance	123.00	60.00	63.00
Rent and electricity ...	2,175.98	2,150.00	25.98
Telephone and telegraph	195.49	270.00	74.51*
Dues and memberships..	81.50	.....	81.50
Prizes	225.00	.....	225.00
Unallocated	236.73	240.00	3.27*
Total expenditures ..	94,704.05	85,000.00	9,704.05
Excess of revenues over expenditures (expenditures over revenues*)	9,453.46*	2,000.00	11,453.46*

Exhibit E

MEDICAL DEFENSE FUND

Revenues:		
Transfer of applicable portion of dues	4,801.25	
Interest earned—U. S. Treasury bonds	809.53	
Amortization of discounts—U. S. Treasury bonds	4.80	
Total revenues		5,615.58
Expenditures:		
Malpractice fees	4,636.67	
Legal fees	2,640.00	
Stationery and printing.....	118.61	
Total expenditures		7,395.28
Excess of expenditures over revenues		1,779.70

STUDENT LOAN FUND

Cash balance, September 30, 1959....		1,470.06
Revenues:		
Collection of student loans.....	2,982.79	
Interest earned	145.72	
Gift	10.00	3,138.51
		4,608.57
Expenditures—loans to students.....		2,543.34
Cash balance, September 30, 1960....		2,065.23

Chairman of the Council

The Council of the Indiana State Medical Association held its first meeting of the year following the close of the Annual Meeting of the House of Delegates on Oct. 5, 1960.

The first item of business considered by the Council was the election of two members to the Executive Committee. Upon motion properly made and seconded and carried, Dr. Donald E. Wood, Indianapolis, and Dr. Wendell E. Covalt, Muncie, were re-elected as members of the Executive Committee.

The next item of business was the election of the Chairman of the Council by secret ballot. Dr. Maurice E. Glock, Fort Wayne, was re-elected Chairman of the Council.

Emergency Session: December 26, 1960

An emergency session of the Council was called Dec. 26, 1960, for the purpose of discussing the action taken by the House of Delegates at its meeting on Oct. 5, dealing with the requirement of a mandatory loan, or donation, by each member of the Indiana State Medical Association in the amount of \$50 to assist in financing the construction of a new headquarters building. The meeting was made necessary by the action of a few of the societies who threatened to flatly refuse to require this payment on the part of their membership due to the question as to whether the action of the House constituted a legal action.

A full discussion of the problem at hand was held, with a review of the Constitution and Bylaws of the Association, and discussion of that by the legal counsel of the Association.

As a result, it was found that the action, as adopted by the House, was administratively unenforceable under the Constitution and Bylaws. Therefore, the Council drafted a letter which was to be sent by each Councilor to each society in his district informing them that the action of the House making this mandatory for active members was not enforceable and setting forth they hoped the societies would encourage their members to assist in the building program on a voluntary basis.

January 15, 1961 Meeting

The Council convened at 10:00 on Jan. 15, at the Student Union Building, for its regular mid-winter meeting.

Each of the councilors reported on the reaction of the societies within their district following the action taken by the Council at its emergency session in December.

The Treasurer gave a financial report and presented to the Council the audit for the fiscal year, as submitted by Wolf and Company, Certified Public Accountants. This report was published in full in *The Journal* issue of May, 1961, on page 697.

The AMA Delegates, Dr. Harold Ochsner and Dr. Robert Brown, reviewed the actions taken by the AMA House of Delegates during the Clinical Meeting held in Washington, Nov. 28-Dec. 1.

The Executive Committee reported its position regarding participation in the National Science Fair and the communication it had received from the Commission on Medical Education and Licensure, asking for reconsideration of the action taken by the Executive Committee, reporting further that the Executive Committee, after due consideration of the recommendations of the Commission, re-affirmed its vote that the Association would not participate in the 1961 Science Fair, and that they are referring this matter to the Council for their information and discussion.

The Council took action to participate in the 1961 Fair by contributing up to two thousand dollars (\$2000.00) to defray the traveling expenses of the regional winners in the biological science fields.

The Council had a report from the chairman of the Commission on Medical Education and Licensure concerning the resolution which was referred to his commission by the House of Delegates. They recommended that the resolution was not practical and that the commission recommended to the Council that the resolution be tabled. The Council accepted the recommendations of the commission.

The Chairman of the Building Committee reported to the Council the activities of his Committee and the status of the building program. Also reviewed was the number of members of the Association who had contributed to the building fund. For the further discussion of the building program, the officers of the Marion County Medical Society appeared before the Council for a discussion of the Association's building program.

The Chairman of the Committee on Student Loans reported on the activities of his committee. The Chairman also pointed out that the House of Delegates had adopted the report of his committee in which they had recommended the reduction of interest rates on student loans to 2%, pointing out that the House had adopted the report of the Reference Committee. The committee has voted to recommend to the Council that the interest rate of 2% be made retroactive to apply to loans granted prior to Oct. 5, 1960. After a full review of the reference committee and the action taken by the House and a discussion of this problem, the Council voted to disapprove the recommendations of the Student Loan Committee and the lower interest rate would apply only on loans made following the action of the House of Delegates.

The Liaison Committee between the Council and the Blue Shield Plan reported to the Council of its meetings with the Blue Shield Board and a discussion was held regarding the advisability of requesting the Blue Shield to refer all apparent abuses of the Plan to the Commission on Medical Economics and Insurance, or

the Grievance Committee, and if these bodies felt it necessary, they could bring them before the Council.

The Council, in accordance with its prerogative, nominated for membership-to-large to the Board of the Blue Shield Plan for three year terms (expiration March 1, 1964) the following: John W. Beeler, M.D., Indianapolis, to succeed himself and W. E. Bayley, M.D., of Lafayette, to succeed Marlow W. Manion, M.D.

The President reported on his meeting with the Judicial Council of the American Medical Association, during the interim session in Washington, for further discussion of the osteopathic question.

The chairman of the Commission on Convention Arrangements reviewed the outline for the 1961 Annual Meeting for the information of the Council.

The Council had a report from the Commission on Legislation and specifically discussed was the bill known as the Professional Corporate Practice Bill, and after full discussion of this, the Council took action instructing the Legislative Commission and the staff to actively oppose the passage of this proposed legislation.

The Council also had a report from the Commission on Governmental Medical Services in which they urged every resource of the Association to be placed behind the passage of legislation in the Indiana State Legislature to implement the provisions of the Kerr-Mills Bill.

The Council received from the Headquarters Office a detailed, tabulated report of members of each county medical society in each councilor district as of Dec. 31, 1960. This report, in detail, was published in the May, 1961, issue of the *State Journal*, page 704.

Routine handling of remission of dues of various members, as recommended by their county medical society, was handled by the Council.

The Chairman of the Council, and the State Health Commissioner reported to the Council their impressions of the White House Conference on Aging, held in Washington, on Jan. 6, 1961.

The State Health Commissioner reported to the Council a recent survey which had been made concerning the prophylaxis program on rheumatic fever, and the Council approved the addition of oral penicillin and oral sulphadiazine in addition to injectable penicillin to the rheumatic fever prophylaxis program.

The Health Commissioner also requested the opinion of the Council concerning the establishment of a Registry for Rheumatic Fever, and the Council expressed an opinion approving the establishment of a follow-up registry on these patients.

The State Health Commissioner also reported a request which he had received from the National Office of Vital Statistics in which they request permission be granted to make a survey in Indiana to derive estimates on hospital utilization by deceased persons during the twelve months prior to death. After a full explanation of the program, and a full discussion, the Council approved the pilot study as outlined by Dr. Offutt.

Dr. Offutt reported on many other programs and activities currently being conducted by the State Board of Health.

The Council received a Resolution from the Commission on Public Health and from the Commission on

Voluntary Health Agencies in which the commissions pointed out that members of the Indiana State Medical Association continue to accept the responsibility for a practical program for the prevention, control and eradication of tuberculosis. The Council approved the resolution, as submitted, and instructed the Commissions to continue their work in this field.

Dr. Stewart T. Ginsberg, Commissioner of Mental Health in the State of Indiana, reported on his department and several conferences which he had attended, both at a state and at a national level, to discuss the handling of mental cases.

Dr. Philip B. Reed, Chairman of the Grievance Committee, gave a comprehensive report of matters coming before his committee and reported on the Medical Discrepancies Committee which the American Medical Association was planning to establish.

Dr. Norman R. Booher, Chairman of the Commission on Voluntary Health Agencies, came before the Council and discussed possible legislation for criteria which could be used by the American Medical Association, officially endorsing and approving programs for the various voluntary health agencies. After a full discussion of this report the Council approved the criteria method, as recommended by the commission, and instructed the commission to proceed along this line.

The Council received a report from the Commission on Medical Economics and Insurance stating that two or three different insurance programs had been referred to their commission for study and the Council reaffirmed its previous position of not approving any one carrier of insurance on members of the Indiana State Medical Association.

A discussion of the Constitution and Bylaws was held and the Council instructed the Commission on Constitution and Bylaws to prepare an appropriate amendment to Section 12, Chapter XXVI of the Bylaws to provide that new members elected for the first time after Oct. 1 of any year shall pay fifty percent (50%) of the total regular dues.

Dr. John D. Van Nuys, Dean of the School of Medicine, appeared before the Council and reviewed plans and programs of the Indiana University Medical School and reported on the progress of the establishment of a new hospital for the medical school campus.

April 9, 1961 Meeting

The Council convened at 10:00, on Sunday, April 9, in the Roof Lounge of the Indiana University Student Union Building for its annual spring meeting.

Reports were received from the councilors concerning the activities within their respective districts.

The reports of the officers of the Association also were received by the Council and the Treasurer presented the financial report for the first six months of the fiscal year and reported that in spite of the fact that a deficit budget had been adopted, if we could hold our position for the last six months, we should conduct the year with a balanced budget.

The Chairman of the Building Committee reported to the Council that the Association had been successful in its litigation for the re-zoning of the property at 3935 North Meridian St. and reported in detail the

plans for the new building and the architect's estimate of costs for same. The report was accepted and approved by the Council and the Building Committee was commended for its hard work in bringing the building this close to realization.

The President, in the absence of the Chairman of the Student Loan Committee, reported on the activities of this committee, pointing out that more than \$33,000 of the \$40,000 had been loaned and that about \$6,000 remained in the fund for future loans. He also reported on the discussion held concerning the higher education loan plan which the Association might conceivably consider inasmuch as for every one dollar invested in this fund by the Association it would enable loans of \$12.50 to be made to needy students. The Council referred this to the Committee on Student Loan for further investigation and study and to report back to the Council their findings and recommendations.

A report was received on the operation of the Medicare Program.

The Council Liaison Committee with the Blue Shield reported to the Council and announced that the Blue Shield Plan was bringing out a \$250 schedule which might conceivably be used for aged patients and indigent cases.

Dr. Mericle, Chairman of the Osteopathic Committee, reported on meetings held by the Ad Hoc Osteopathic Committee on Jan. 15 and March 19. Following the report, the Council voted that the committee should continue to function.

Dr. Don E. Wood, co-chairman of the Commission on Legislation, reported on the commission's activities during the 1961 Assembly of the State of Indiana, and discussed in detail the method in which the Kerr-Mills Bill would be implemented in the State of Indiana.

The Council took action to commend the commission and the headquarters staff of the Association for their effective work during the Legislative session.

Routine handling of the remission of dues was handled by the Council.

The Executive Committee referred to the Council several questions:

(1) Possibility of surveying all the hospitals in the State of Indiana to determine the number of people over 65 admitted and the method used for payment of their hospital charges. The Secretary of the Board of Health announced that they were in the process of preparing a survey and would be very happy to include this question in their survey. This was approved by the Council.

(2) A Resolution from the North Carolina Medical Society concerning the legislative program of the American Medical Association was read and Indiana's delegates to the AMA were instructed to support this resolution.

(3) The Executive Committee referred a resolution dealing with the proposed dues increase of the American Medical Association, as received from the Nebraska State Medical Association.

Also read was the memorandum from the American Medical Association, entitled, "You Have a Right to Know." The Council directed a copy of this publication be sent to each county medical society for their

comments, and further recommended that this matter be discussed at the respective district meetings, so that the AMA Delegates could express the sentiments of the majority of physicians in Indiana on this question.

(4) The Executive Committee called attention to the Council that they had not established a cut-off date for the refunding of building fund contributions and they felt such a date should be established. Upon motion properly made, seconded and carried, the date of April 9, 1961, was established as the cut-off date.

(a) Further action of the Council regarding the Building Fund was taken and the Executive Secretary was instructed to notify each county medical society that all new members joining the society for the first time would be expected to pay the \$50.00 to the Building Fund.

(5) The committee reported its meeting with the officers of the Auxiliary and the action taken to subsidize this organization and that the Executive Committee had recommended to the Auxiliary to seriously consider increasing their dues in order to conduct the program as planned.

The Council next received a report from Dr. Philip B. Reed, Chairman of the Grievance Committee, who reported on matters appearing before his committee since the last meeting of the Council.

Doctor John D. Van Nuys, Dean of the Indiana University School of Medicine appeared before the Council and reported on the affairs of the University, announcing plans to get 205 freshmen in the next class.

He also reported that the Legislature had appropriated \$300,000 for the repairs of the existing plant and an additional two million dollars to start a new teaching hospital for adult patients.

He further reported that the Riley Foundation had appropriated \$600,000 for improvements to Riley Hospital and the State matched this with an additional \$400,000, making a total of one million dollars for the construction of new operating rooms and a new rehabilitation department at Riley Hospital.

Dr. Van Nuys also pointed out that one of the greatest problems they were having at the University now was the need of additional sources for student loans.

Dr. Offutt, Secretary of the State Board of Health, appeared before the Council and reported on actions taken by the State Legislature affecting the Board. He announced that the Legislature had abolished the Department of Health, as established under the Craig Administration, and had re-distributed the responsibilities of this Department to the State Board of Health.

Dr. Offutt also discussed the question of a polio vaccination program and publicity, and the Council voted that a letter be sent to all county medical societies, encouraging them to develop programs on polio immunization and to report their programs, as established, to the State Board of Health.

July 9, 1961 Meeting

The Council convened in the Student Union Building, Indianapolis, Ind., at 10:00 Sunday, July 9, 1961, for its annual summer meeting.

At this time it was announced that Dr. John M. Paris was re-elected Councilor of the third District for a three-year term, ending October, 1964; Dr. K. O. Neumann was re-elected Councilor of the Ninth District for a three-year term, ending October, 1964; Dr. Milton F. Popp, was elected Councilor of the Twelfth District for a three-year term, ending October, 1964; and Dr. John L. Langohr was elected as Alternate Councilor of the Twelfth District to fill the unexpired term of Dr. Popp.

The Council was also informed that Dr. Fletcher W. McDowell, Muncie; Dr. R. R. Calvert, Lafayette and Dr. Mahlon F. Miller, Fort Wayne, had been re-nominated by their respective districts for election to the Board of Directors of Mutual Medical Insurance, Inc.

The Treasurer reported on the affairs of the Treasurer's office, and the Chairman, in the absence of the President, made a report on behalf of the President, concerning some of their views regarding our participation in the meetings of the AMA and recommended consideration of the following points:

(1) That the Indiana State Medical Association must become more active at the national level.

(2) Study should be given to the forming of a committee at the state level to guide the Association's policies and to assist Indiana's AMA delegates.

(3) Our AMA delegates should have more active direction from the State Association.

(4) The Association should consider paying the expenses of the alternate delegates to the AMA in order that these men might be well trained and provide potential future leadership at the national level.

The chairman also announced that it was the view of the Executive Committee that the AMA Delegates should meet with the Executive Committee of the Association prior to each meeting of the AMA House of Delegates in order that they might have a better understanding of the objectives of the Indiana State Medical Association and in the questions which we might be interested in presenting at the national level.

We also feel that it should be spelled out exactly who should lead the delegation and that there be long-range planning in order that our delegates become interested in definite areas of activity at the national level.

Following this, the AMA Delegates reviewed the annual meeting of the AMA and informed the Council of various actions taken at the national meeting.

The Chairman of the Building Committee reviewed for the Council the progress of the Building Committee and informed them it had been necessary for the Committee to reanalyze their plans in order to bring the cost of the building within the budgetary limits.

Accordingly, the Council adopted a resolution, empowering the Building Committee to negotiate with the lowest bidder for a building that could be built within the budgetary figure.

Dr. James O. Ritchey, on behalf of the Chairman Doctor Harry P. Ross, of the Student Loan Committee, discussed the United Student Aid Funds, Inc., which has been established in Indiana under the name of Higher Education Loan Plan.

Dr. Ritchey reported that on investigation it was

found that any money contributed to this effort by the Association would not have the identity of the Association attached thereto.

Dr. Ritchey pointed out the general feeling of the sub-committee which had been requested to study this matter was that the Association should not enter into this arrangement for student loans, but that the matter probably should be studied further.

Dr. Ralph C. Eades reviewed the events transpiring at the recent National Science Fair.

Dr. William Challman gave a report covering the activities of the Liaison Committee between the Council and Blue Shield Plan.

Dr. Challman reported further on the action taken by the AMA at its annual meeting on the questions of osteopathy. The Headquarters Office was instructed to send a report of the AMA action to the secretaries of all component county medical societies.

A report was received from the Commission on Convention Arrangements covering the program and plans for the Annual Meeting of 1961.

The Council also received a report from the Co-Chairman of the Commission on Legislation, who reported on the status of legislation of interest to the Medical Association.

The Council discussed the advisability of recommending that a physician be appointed to each of the county welfare boards in order that their services would be available in helping resolve many of the problems that arise in the administration of the welfare medical care programs. The Council resolved this question by suggesting that a letter, calling attention to this possibility, be sent to each county medical society, and those feeling that it would be a good idea to have a physician on the welfare board are to contact local officials and discuss this possibility with them.

The Council thoroughly discussed the subject of dividing the Seventh Councilor District into two districts and finally referred this to the Commission on Constitution and Bylaws for further study.

The Council next received a resolution from a county medical society concerning the 15-day re-confirmation procedure instituted by the Blue Cross Plan. The Council thoroughly discussed this question and the matter of its implementation and agreed that Indiana physicians should not be forced to participate in this plan.

The Council approved recommendations of the Executive Committee as follows:

- (1) That the AMA delegates meet with the Executive Committee prior to the AMA meetings;
- (2) That a brochure be compiled outlining the duties, etc., of the delegates and alternate delegates;
- (3) That the Association defray the expenses of alternate delegates to attend the meetings of the AMA;
- (4) That additional personnel be employed on a part time basis to assist Mr. Waggener in the Headquarters Office.

Dr. Philip B. Reed, Chairman of the Grievance Committee, then appeared before the Council and reviewed the activities of this committee and discussed the report of the AMA Medical Disciplinary Committee.

Dr. John D. Van Nuys, Dean of the Indiana University School of Medicine, reported to the Council on the plans for a new hospital and the remodeling program at Riley Hospital for Children.

He also announced the several grants which had been received by the University—one amounting to \$4,300,000 over a seven-year period—one for \$680,000 over a three-year period and one for \$900,000 extending over a six-year period.

Dr. Andrew C. Offutt, Secretary of the State Board of Health, reported to the Council various items of interest concerning programs and activities of the State Board of Health.

Dr. Emmett B. Lamb, Chairman of the Commission on Public Health, reported to the Council a study which they had been making concerning the use of oral polio vaccine.

The Council next approved the establishment of an eye bank by the Indiana Lions' Club.

The Council next received a report from a sub-committee of the Commission on Public Health and the Commission on Voluntary Health Agencies, presented by Dr. Richard Swan and Dr. Gerald Kempf, which the Council approved and recommended that a full time committee be appointed through the Indiana State Board of Health to include members of these commissions, the Board of Health, and the Tuberculosis Association, to coordinate our various efforts in dealing with the tuberculosis problem.

Dr. Nathan Salon, Fort Wayne, Chairman of the Commission on Aging, reported to the Council the events concerned with the Second White House Conference on Aging.

The Council next elected Drs. James W. Denny and Roy V. Myers, of Indianapolis, for three-year terms on the Trust Committee of the Indiana Medical Education Foundation.

The Council, on a rising tribute, adopted a resolution at the untimely death of Dr. Cleon A. Nafe and ordered a copy of this be spread upon the records and transmitted to his family.

It was then announced that Dr. Nafe's death created a vacancy on the Board of Directors of the Blue Shield Plan. Dr. Nafe was a member-at-large and his term would not have expired until March, 1963. Upon motion duly made and seconded, the Council recommended to the Board of Directors the election of Dr. James M. Leffel, Indianapolis, to complete this unexpired term.

As Chairman of the Council, I desire at this time to express my thanks to the members of the Council and all officers of the Association and the members of the Association for their kind assistance and cooperation during my term as Chairman of the Council. It has been a sincere pleasure to work with all of them and I hope that during the past year the Council has judiciously handled the matters which have been before it to the benefit of the entire medical profession and the public as well in the State of Indiana.

MAURICE E. GLOCK, M.D.
Chairman of Council

First Councilor District

The First District meeting was held at the Country Club, Evansville, on May 18, 1961, with Mr. T. C. Petersen of the American Farm Bureau, Chicago, as the guest speaker. Mr. Petersen gave a very interesting talk on "Socialism and Government."

District officers were elected as follows: Drs. Gilbert Wilhelmus, Evansville, president; Michael Monar, Rockport, vice president; J. Guy Hoover, Evansville, secretary-treasurer; Patrick J. V. Corcoran, Evansville, alternate councilor (re-elected); and George Willison, Evansville, Blue Shield Board representative.

For the first time in history, the Woman's Auxiliary of the First District met jointly with the First District Medical Society, attended the dinner, heard the speaker, and then held their separate meeting for the election of officers.

WILLIAM B. CHALLMAN, M.D., *Councilor*

Second Councilor District

The Second District meeting was held at Washington, on June 15, 1961, with a total attendance of 50. Senator Capehart spoke on current political problems. Jerome Graf, M.D., Bloomfield, was elected President of the District for the coming year and J. S. Brown, M.D., Carlisle, was re-elected Secretary. The practice of reporting to the district members ISMA activities by Newsletters was instituted during the year.

E. T. EDWARDS, M.D., *Councilor*

Third Councilor District

The Third District had its annual meeting in Huntingburg May 11, 1961, with 25 members present. This was not a large attendance, but about average for this district. Presiding was Dr. Elton Heaton, Huntingburg; Dr. Allen Scales acted as secretary. The first order of business was election of officers for the coming year, and a selection of the site. This was quickly accomplished by electing Dr. Cannon and Dr. Brown from New Albany and selecting New Albany as the site for the 1962 meeting. At this time, the undersigned was re-elected as Councilor of the Third District for his second and last term. The President of the Association, Dr. Guy Owsley, then spoke regarding some of the legislative problems confronting us, and then made a plea for contributions to the building fund so that the Third District would have a better percentage.

I want to extend my congratulations to the small county societies, namely—Scott, Washington, Harrison, Crawford, and Orange—which have contributed 100% and I wish I could say the same for the larger counties of the district.

The scientific meeting was conducted by Dr. Mel Welborn of Evansville, who gave us some very interesting and valuable suggestions about diagnosis, operations and followup care of some of the major surgical problems that he sees in his hospital.

The Third District has continued to attract new physicians and we have not had many deaths this past year. There have been no disciplinary problems brought

to the attention of the Councilor and this is always a source of great pride.

One of our problems, and I think it is true of all district societies, is what to do to get the members to come to the meetings. This is a very important meeting for every physician in every district, because this is the time he presents his suggestions and criticisms to the Councilor, and this is the time in which he has an opportunity—once every three years—to vote on who is to represent him on the Council. The Floyd County Officers have assured me they are going to plan something different for May of 1962 to see if we can't get at least a third of the members to attend.

I am grateful for your loyal and continuing support and promise three more years of continued attention to our district.

JOHN M. PARIS, M.D., *Councilor*

Fifth Councilor District

The affairs of the Fifth District, for the most part, have been uneventful for the years 1960-1961. No actual society complaints have come to my attention. There has, however, recently been a bit of adverse medical publicity from the Parke-Vermillion area in the form of anonymous letters appearing in the Clinton newspaper. Investigation of this is being made and it is hoped it will be corrected.

The annual Fifth District meeting was held at Turkey Run and Rockville, on May 17, 1961, with Parke-Vermillion Society as hosts. The group was entertained in the afternoon with golf, bowling and boating on the recently completed lake near Rockville. Late in the afternoon at the Turkey Run Inn a business meeting was held.

Officers elected for the year were Drs. Arnold W. Kunkler, president; Paul Siebenmorgen, vice-president; A. W. Cavins, alternate councilor, and Hubert T. Goodman, Blue Shield Board member, all of Terre Haute.

Terre Haute was selected as the meeting place for 1962. Refreshments and a bountiful dinner were served. This was followed by an interesting and entertaining talk by Dr. William P. Allyn, Ph.D. Subject: "Are People Human." The meeting was well attended and the hosts were highly complimented.

V. EARLE WISEMAN, M.D., *Councilor*

Sixth Councilor District

The past year has been a very active one in the district. Members have been contacted regarding welfare legislation, and the Auxiliary members also have been contacted. Contacts were made with various members of the State legislature. A general feeling of good fellowship has prevailed throughout the whole district.

At a meeting May 11 in Rushville, members of the Sixth District elected as district society officers for the coming year Drs. John A. Davis, president; Davis W. Ellis, vice president; Perry F. Seal, secretary-treasurer; William Tindall, councilor, and Frank Green, alternate councilor. A resolution expressing appreciation of the district society to Dr. Guy A. Owsley, Dr. Maurice E.

Glock, Dr. Harry R. Stimson and James A. Waggener, for their selfless devotion to duty for the best interests of the health of the general public and for their services to the medical profession, was adopted.

A meeting regarding the building program was held in Shelbyville at which time Dr. Owsley and Dr. Glock discussed the program and the preceding arrangements that brought this meeting into being. The need for the Indiana State Medical Association to have a building of its own was discussed at great length. At the conclusion of the meeting it was generally agreed that everybody acted in good faith, and there was a much better understanding by the members of the various counties represented at this special meeting.

HARRY PLUMMER ROSS, M.D., *Councilor*

Seventh Councilor District

The annual meeting of the Seventh District Medical Society was held May 17, 1961, at the Hillcrest Country Club, Indianapolis.

Dr. Ray D. Miller, of Martinsville, was elected President-elect of the Society. He will succeed Dr. Malcolm O. Scamahorn, who will serve as President during 1961-62, succeeding Dr. Ted L. Grisell, of Indianapolis.

Dr. Herbert L. Egbert, of Indianapolis, was re-elected Secretary-Treasurer.

Mr. Frank Woolley, field secretary for the American Medical Association, was guest speaker following a dinner in the clubhouse, attended by approximately 150 Society members and their wives.

Dr. Edwin R. Eaton, of Indianapolis, was winner of the Society's golf tournament, which was played in the afternoon on the club course.

RALPH V. EVERLY, M.D., *Councilor*

Eighth Councilor District

The Eighth Councilor District Medical Society held its annual meeting Wednesday, June 14, 1961, at the Delaware Country Club, Muncie.

Doctor Stanley W. Burwell, Muncie, president of the society, was in charge of the meeting. Golf games were arranged for the doctors in the afternoon and also golf and bridge for the doctors' wives who attended.

A short business meeting was held at 5:30 p.m. with Dr. Burwell presiding.

Dr. Guy Owsley, ISMA President, was introduced, and gave a talk on the affairs of the State Medical Association. He also explained the status of the headquarters office building program at this time.

At the business meeting officers for the coming year were elected as follows:

President: Leroy B. Chambers, M.D., Chambers Medical Clinic, Union City.

Secretary-Treasurer: Carol R. Chambers, M.D., Chambers Medical Clinic, Union City.

Fletcher W. McDowell, M.D., Muncie, was re-elected to the Blue Shield Board from the Eighth Councilor District.

Following the business meeting a social hour was enjoyed in the parlor of the Country Club by the doctors and their wives and guests.

At eight o'clock in the evening a buffet dinner was served to about 75 members and their guests.

There was no formal program arranged for the meeting.

Mr. James A. Waggener, Executive Secretary and Mr. Howard Grindstaff, Field Secretary from the State Headquarters office, were present.

GORDON B. WILDER, M.D., *Councilor*

Ninth Councilor District

The Ninth Councilor District Medical Society enjoyed a relatively quiet year. Bi-monthly letters were sent to each society by the Councilor in an effort to help each society be better informed, and personal visits were made to six societies.

Osteopathic matters and the building program occasioned much discussion and wide disagreement of opinion. 100% of the membership of Fountain, Montgomery, Tipton, and Warren Counties have contributed to the New Building Fund. It was gratifying to note the increased participation of members on committees and commissions during the past year.

The annual meeting of the Ninth District Medical Society was held in Crawfordsville May 18, 1961. Members of the Montgomery County Medical Society were genial hosts. Dr. J. M. Kirtley served as president and Dr. W. J. Shannon served as secretary-treasurer.

Dr. Guy Owsley, ISMA President, reported on the "State of the Association" and Mr. Richard Kilborn summarized changes in Blue Shield contracts. A brief report was made by the Councilor.

Dr. K. O. Neumann was re-elected as Ninth District Councilor for a three-year term beginning in October, 1961, and Dr. R. R. Calvert was re-elected as the Ninth District representative on the Blue Shield Board beginning in March, 1962.

Discussion of the proposed increase in AMA dues and the problem of medical consultation on Social Security reports ended the business meeting. An invitation was received, and accepted, to hold the Ninth Councilor District Meeting in Hamilton County next year; the date, location, and officers to be selected by the host society.

A scientific program was presented. This included a panel discussion on Chronic Duodenal Ulcer with T. C. Haller, M.D., F. H. Priebe, M.D., Wemple Dodds, M.D., and H. C. Wallace, M.D., followed by a presentation by Charles H. Brown, M.D., of the Cleveland Clinic, on Psychosomatic Factors in Gastrointestinal Disorders. Both presentations evoked many questions and prolonged discussion.

Women guests were entertained by the Woman's Auxiliary of the Montgomery County Society at a luncheon followed by an afternoon of bridge and tours of the Ben Hur Museum, Lew Wallace Study and Lane Place.

The meeting concluded with a social hour and dinner at the Crawfordsville Country Club.

K. O. NEUMANN, M.D., *Councilor*

Tenth Councilor District

The Tenth District Society held two meetings during the past year. The first of these occurred Oct. 12, 1960 at Phil Smidt's Restaurant in Whiting.

Dr. Ralph C. Eades, Valparaiso, Alternate Councilor for the Tenth District, presided at the dinner meeting.

Dr. Harry R. Stimson of Gary, new President-elect of Indiana State Medical Association, received an ovation from 118 doctors and wives attending.

Dr. Eades introduced Dr. J. P. Vye of Gary, Tenth District Councilor; Dr. F. F. Boys, East Chicago, President of Lake County Medical Society; Mr. Howard Grindstaff, Field Secretary, Indiana State Medical Association; and Mr. L. E. Converse, Director of Physician Relations, Indiana Blue Shield.

The minutes of the spring meeting were read and approved.

Dr. Eades introduced Dr. Guy A. Owsley, President, the Tenth District with the following results:

Dr. Milton Gevirtz, Hammond, President

Dr. Leonard Neal, Hammond, Secretary

Dr. Harry R. Stimson, Gary, Board member, Indiana Blue Shield

A movie concerning the "Save the Indiana Dunes" movement was shown.

Dr. Eades introduced Dr. Guy A. Owsley, President, Indiana State Medical Association, who gave an inspiring talk regarding the Health Organization for Political Education. He urged all doctors to vigorously support the organization including financial contributions to Dr. Joseph Black, treasurer, Seymour. Dr. Owsley was warmly applauded for his interest and energy in encouraging doctors to take a more active role in elections and other forms of politics.

The second meeting was held May 10, 1961, at the Flame Restaurant in Gary.

Dr. M. B. Gevirtz, President, Indiana Tenth Medical District, presided at the meeting which began at 4:00 p.m. at the Flame Restaurant in Gary. He introduced Dr. George Young, representing the Indiana Academy of General Practice, who presented the Academy's "Road Show" program, including Dr. Eugene Senseny, Proctologist, Fort Wayne, who spoke on "Office Proctology" and Dr. John Googins, Epidemiologist from the Indiana State Board of Health who then discussed "The Hepatitis Problem in Indiana."

Forty-five members attended the afternoon session. Dinner was served at 7:00 p.m., during which Dr. Harry R. Stimson, President-elect of the Indiana State Medical Association, was introduced, along with Mr. Howard Grindstaff, Field Secretary, who discussed the "King Bill" and other legislative matters; Dr. Francis Land, President of the Indiana Academy of General Practice; Mr. Royce Coulson and Mr. Gil Krause, representatives of the Eli Lilly Company, sponsors of the "Road Show" program; and Dr. J. P. Vye, Tenth District Councilor.

Dr. L. Neal, Tenth District Secretary, read the minutes of the October meeting, which were approved as read.

Mrs. Burton Kintner, President of the Auxiliary to

the Indiana State Medical Association, held a special meeting with 40 wives to discuss Auxiliary matters.

Dr. Gevirtz then presented Dr. George Young to the 75 physicians to continue with the IAGP "Road Show." During the evening program, Dr. Googins discussed the survey being done in the Lake County hospitals on the "E. Coli 0111B4 Problem." He stated that while the present figures were inconclusive, the study would continue and periodic reports would be made to the profession regarding it.

Dr. Eugene Senseny then presented a talk, accompanied by slides, on "Clinical Aspects of Proctology."

With the assistance of several officers of the various county societies, an intensive effort has been made during the year to obtain maximum support for the State Association's headquarters building program. At the last report, close to 90% of the doctors in the district had made contributions to the program, and it is our hope that with the exception of cases where hardship may exist, the district may eventually be able to say that 100% of its membership supported this program.

J. P. VYE, M.D., *Councilor*

Eleventh Councilor District

This Councilor took office in October, 1960. This was at the time of the controversy concerning the building. During this time it was necessary to travel to Howard County to explain the assessment for the building. In addition to this the Councilor has attended meetings of the Huntington County Medical Society, the Grant County Medical Society and recently visited the Miami Medical Society in preparation for the fall eleventh Medical District Meeting. On one occasion the Councilor and his wife went to Logansport for an A.M.E.F. dinner.

In the first report given at the Eleventh Medical District meeting the Councilor informed the membership that it was his feeling that the reason medicine had toppled from its pedestal was due to the fact that too many people were willing to take small chunks from the bottom rather than to rise to the heights of a professional career, and that too many of the profession had lost their professional status and had forgotten the patients. It was felt at that time and continues to be the opinion of this Councilor that if all of those in medicine were to take good care of their patients we would have no further difficulty.

The meeting held in Huntington this spring was very informative. The organizational side of the meeting consisted in a debate as to whether or not this district should continue two meetings a year. This will require a constitutional amendment to change. A motion to make such an amendment was made at the May meeting in Huntington, Indiana. This will again be read and voted upon in the September meeting.

The Councilor has attended all Council meetings since taking office, and has attempted to participate in the proceedings of each meeting and to protect the rights, privileges and interests of his district at such meetings.

EUGENE S. RIFNER, M.D., *Councilor*

Twelfth Councilor District

The Twelfth District annual meeting was held May 17, 1961, at Columbia City, Indiana, with the Whitley County Medical Society serving as hosts. At the business meeting Milton F. Popp, M.D., was elected to a three-year term as Councilor, and John Langohr, M.D., was elected as alternate councilor. Mahlon F. Miller, M.D., was selected to succeed himself to a three-year term on the Board of Directors of Blue Shield. S. C. Michaelis, M.D., was elected president of the District Society. Dr. Harry Stimson, president-elect, Indiana State Medical Association, gave a report on state matters. Francis L. Land, M.D., gave a report regarding AMA problems. Eugene Senseny, M.D., gave a report from the State Legislative Committee. Mr. Thomas L. Hendricks, Jr., gave very interesting and entertaining remarks and greetings from AMA Headquarters.

Following a cocktail hour and excellent dinner we were entertained by a very informative discourse by Dr. John H. Furbay, of T.W.A. Airlines, regarding our shrinking world and expansion of new countries. This was very stimulating and was well received by a large group.

The next annual meeting will be held in Fort Wayne in May, 1962, as a joint meeting with the Fort Wayne Medical Society.

MAURICE E. GLOCK, M.D., *Councilor*

Thirteenth Councilor District

The Thirteenth Councilor District meeting was held in Elkhart on Sept. 28, 1960.

The following officers were elected:

Charles Muhleman, M.D., LaPorte, president
D. Logan Dunlap, M.D., South Bend, vice-president
James Wilson, M.D., South Bend, secretary-treasurer
R. E. Nelson, M.D., South Bend, alternate councilor
Robert H. Denham, M.D., South Bend, Blue Shield Representative.

The Scientific Program was held in the Ames Laboratory auditorium. A paper was presented by Dr. Felix Wroblewski of the Sloan Kettering Institute on "Enzymes in Clinical Diagnosis" and a discussion on "Research by the General Physician in his Practice" was presented by Doctor I. Phillips Frohman, of Washington, D. C.

A social hour was held at the offices of the president of the 13th District, Dr. Tom Elliott, Elkhart Clinic.

In the evening we were pleased to have Dr. Paul Dudley White give a speech before 350 doctors and their wives on "The Doctor as a Patient." He was brought to the meeting by the Elliott Foundation of Elkhart.

Notables in attendance were Earl W. Mericle, president, Guy A. Owsley, president-elect and James A. Waggener, Executive Secretary, ISMA.

The invitation from LaPorte to hold the next meeting there was accepted; however, due to the unusual nature of the program it is to be held at the Indiana Club in South Bend late in September. The speaker for the program and the exact date cannot be given at this time.

BURTON KINTNER, M.D., *Councilor*.

The Journal

The 1960-61 business record of *The Journal* can be summarized in a few words. Less advertising revenue, smaller journal, less expense and break-even on the finances. Details are contained in the report of the Executive Committee.

The slump in advertising is not due to fewer advertisers but to a decrease in the amount and cost of advertising by each advertiser. The change is limited almost exclusively to pharmaceutical ads and is thought to be a secondary effect of the Kefauver investigation. It is hoped, and with some justification, that the slump is temporary.

Special issues during the year included the Heart Issue in February with so much good material that the March number was required for the overflow. The Cancer Issue in April was devoted to exfoliative cytology and was the recipient of many fine compliments. The General Practice Issue in August published papers which were read at the annual meeting of the Indiana Academy of General Practice.

One of the new features originating during the year was a short monthly article describing clinical laboratory procedures suitable for a minimally-equipped laboratory. Many favorable comments have been received and requests for reprints have come from all parts of the United States.

"Pathfinder" continues as a popular feature and "Condensed Cardiology" has been displaced by "Cardiogram of the Month." Dr. Arnold Lieberman's interesting and informative "case reports" are still evoking both formal and informal "rave notices."

For the next few months *The Journal* will carry, as a regular feature, a short article by one of the presidents of the larger pharmaceutical manufacturing firms. The series was initiated by an article by the president of Eli Lilly and Company in May and another by the president of Smith, Kline and French in July.

In the Evaluation and Awards Program of the International Council of Industrial Editors this year *The Journal* scored numerically within less than one percent of its previous excellent grade and merited the comment: "This is a polished professional job—cover material is excellent, line drawings outstanding."

We continue to receive an adequate number of scientific papers, written on interesting, practical and timely subjects.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

Osteopathy, medical discipline, communications, surgical assistants, drug legislation, general practice residencies, relations with allied health professions and services and poliomyelitis vaccine were among the major subjects covered by 115 resolutions and 28 reports acted upon by the House of Delegates at the American Medical Association's 110th Annual Meeting, June 25-30 in New York City.

Dr. George M. Fister of Ogden, Utah, member of the AMA Board of Trustees and previously a member of the House of Delegates, was named president-elect

of the Association. Dr. Fister will become president at the June, 1962, annual meeting in Chicago, succeeding Dr. Leonard W. Larson of Bismarck, N. D., who assumed office at the Tuesday night inaugural ceremony in New York.

The AMA 1961 Distinguished Service Award was voted to Dr. Walter H. Judd of Minneapolis, physician and member of Congress, for his contributions as a medical missionary, humanitarian and statesman devoted to world peace.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 56,315, including 22,681 physicians.

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of AMA policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to reappraise its application of policy regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationship with him should not be deemed unethical."

Medical Discipline

In a major move designed to strengthen the profession's disciplinary mechanisms, the House approved the conclusions and recommendations of the Medical

Disciplinary Committee, with only three word changes. The House discharged the committee with thanks and commendation and directed that its functions be assumed as a continuing activity of the Judicial Council.

One recommendation suggests that "The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level."

Another "encourages and urges that each state association report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year."

The report urged state and county medical societies to utilize grievance committees, as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member.

The House suggested that each medical school develop and present a required course in ethics and socioeconomic principles, and that each state board of medical examiners include questions on ethics and proper socioeconomic practices in all examinations for license.

The report concluded with a recommendation that "American medicine at the national, state and local level maintain an active, aggressive and continuing interest in medical disciplinary matters so that, by a demonstration of good faith, medicine will be permitted to continue to discipline its own members when necessary."

Communications

Acting upon four resolutions related to the Association's public relations program, the House adopted a substitute resolution directing the Speaker of the House of Delegates to name seven elected members of the House as a special committee "to study and continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the American Medical Association, so that the public and the members of the medical profession are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people."

The House agreed with a reference committee opinion that "we have a very adequate division within the AMA capable of implementing any program of communications." The approved committee report also said that "the Communications Division of the AMA needs the active support and cooperation of the House and of all members of the Association."

Surgical Assistants

In considering a Board report and two resolutions on the subject of surgical assistant's fees, the House approved the following five basic principles developed by the Judicial Council and the Council on Medical Service:

"1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient

is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"4. It is ethically permissible for a surgeon to employ other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance.

"This principle applies whether or not an assisting physician is the referring doctor and whether he is on a per-case or full-time basis. The controlling factor is the status of the assisting physician. If the practice is a subterfuge to split fees or to divide an insurance benefit, or if the physician is not actually employed and used as a bona fide assistant, then the practice is contrary to ethical principles.

"5. Under all other circumstances where services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately."

Efficacy of Drugs

The House strongly endorsed a Board report which pointed out the problems that would result from amending the Food, Drug and Cosmetic Act to authorize the Food and Drug Administration to determine the efficacy, as well as the safety, of a prescription drug prior to the approval of a new drug application. The AMA will oppose such legislation before the Kefauver Committee, the report pointed out, on the basis that "a decision with respect to the effectiveness of drugs is dependent upon extended research, experimentation and usage." The House agreed that vesting such authority in the Food and Drug Administration would operate to limit research, the marketing of drugs and the exercise of discretion by the medical profession. "The marketing of a relatively useless drug is infinitely less serious than would be the arbitrary exclusion from the market of a drug that might have been lifesaving for many persons," the House declared.

General Practice Residencies

Eight resolutions were introduced on the subject of creating new two-year, residency training programs in general practice. The House agreed that there appears to be a need for such programs for those individuals who desire more experience in obstetrics and surgery than may be available in the currently existing Family Practice Program. It approved a substitute resolution directing the Council on Medical Education and Hospitals to consider for approval other two-year programs in general practice which incorporate experience in obstetrics and surgery. The Council will review these programs on the basis of their individual merits and conduct a long-range evaluation of the new programs as well as the previously established Family Practice Programs.

Relations With Other Health Professions and Services

The House considered a Board report and 12 resolutions dealing with various aspects of medicine's rela-

tionships with allied health professions and services, including optometry. The Board report recommended the creation of a new AMA Council to handle all the problems involved. The House, however, accepted a reference committee suggestion for establishment of a new Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services. The commission will be composed of seven members appointed by the Speaker of the House. Subcommittees, composed of from three to five members selected by the Commission from lists of names submitted by the scientific sections, will consider problems in specific areas. The commission will correlate and catalogue the reports of the subcommittees and will act as liaison agent between the subcommittees and those AMA Councils where there may be overlapping interests.

Polio Vaccine

The House approved a report by the Council on Drugs on the present status of poliomyelitis vaccination in the United States and urged that it be made available to all physicians through the most effective communications media. The report clearly outlines procedures recommended for implementation of mass vaccination with the new oral vaccine when it becomes available. The House complimented the Council on its "clear and succinct statement on the initiation of the new campaign which will be needed to promote the new vaccine." The House agreed that the report provides the practicing physician with a reliable series of answers to the many questions which will arise during the change-over from Salk vaccine to oral vaccine. The report emphasizes, however, that "physicians should encourage, support and extend the use of Salk vaccine on the widest possible scale at least until the oral polio-virus vaccines currently under development and clinical trial become available."

Miscellaneous Actions

In dealing with resolutions and reports on a wide variety of other subjects, the House also:

Approved the *Guide to Physician Relationships with Medical Care Plans*, submitted by the Council on Medical Service, with these two changes: deletion of item 5 under "Responsibilities of the Medical Society," which said "To recognize that properly qualified physicians employed by, or otherwise serving, medical care plans should not be denied professional rights and privilege because of their service to such plans," and addition of a new item 1 under "Responsibilities of the Medical Care Plan," which reads: "To provide the beneficiary of the plan with free choice of qualified physicians;"

Reaffirmed its support of the *Kerr-Mills* program for the needy and near-needy aged and its opposition to any legislation of the *King-Anderson* type, declaring that the medical profession "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare;"

Approved a markedly expanded *drug information program* submitted by the Board of Trustees and the Council on Drugs;

Adopted the final report of the *Special Study Committee* of the Council on Medical Education and Hospi-

tals and recommended that copies be sent to all medical school deans in the United States;

Decided to hold the *1963 Clinical Meeting* in Portland Oregon, instead of Las Vegas, Nevada, as recommended by the Board;

Approved a plan by the new AMA Department of International Health to cooperate in the recruitment of volunteer physicians for emergency medical service in *foreign mission fields*;

Agreed to an increase of \$20 in the annual AMA *membership dues* to be implemented over a period of two years: \$10 on Jan. 1, 1962, and \$10 additional on Jan. 1, 1963;

Discontinued the Association's *General Practitioner of the Year* award;

Opposed legislative and administrative mandates which would compel physicians to prescribe drugs, or require pharmaceuticals to be sold, by *generic names* only;

Reaffirmed the Association's opposition to compulsory inclusion of physicians under the *Social Security* system;

Urged immediate legislation that will provide strong economic motivation for the construction and maintenance of *fallout shelters*;

Disapproved two resolutions which would have discontinued the scientific activities at the *Clinical Meeting*;

Urged *immunization campaigns* against both tetanus and influenza, and

Asked state and county medical societies to give full support to the *First National Congress on Medical Quackery* to be jointly sponsored next Oct. 6-7 in Washington, D.C., by the AMA and the Food and Drug Administration.

Opening Session

At the opening session on Monday, Dr. E. Vincent Askey of Los Angeles, retiring AMA president, challenged physicians and medical organizations to re-examine their own efforts to strengthen and improve medicine, and he warned against defeatism and failure to accept personal responsibility for answering criticisms. Dr. Larson, then president-elect, called on the profession to strengthen methods of self discipline in both the state and county societies, adding that physicians must be concerned with improper or incompetent practice and unethical actions of all kinds. The 1961 Goldberger Award in Clinical Nutrition was presented to Dr. Frederick J. Stare, chairman of the Department of Nutrition at Harvard Medical School.

Inaugural Ceremony

Dr. Larson, in his inaugural address Tuesday night, said that the really good doctor, guided by the profes-

sional spirit, will always remember that medicine exists for just one purpose—to serve humanity. When the essence of that spirit is diluted or destroyed, either in an individual physician or in a nation, he added, medicine ceases to be a profession in the highest sense of the word. Dr. Larson also presented the Distinguished Service Award medal to Rep. Judd. Entertainment highlight of the inaugural program was a concert by the Montgomery County Medical Society Glee Club of Dayton, Ohio.

Election of Officers

In addition to Dr. Fister, the new president-elect, the following officers were named at the Thursday session:

Dr. Eustace A. Allen, Atlanta, Ga., vice president; Dr. Norman A. Welch, Boston, re-elected speaker of the House, and Dr. Milford O. Rouse, Dallas, Tex., re-elected vice speaker.

Elected to the Board of Trustees were Dr. Wesley W. Hall, Reno, Nev., to succeed Dr. Fister; Dr. Homer L. Pearson, Jr., Miami, Fla., to replace Dr. Julian P. Price, Florence, S. C., and Dr. Charles L. Hudson, Cleveland, Ohio to fill out the term of the late Dr. Cleon A. Nafe, Indianapolis. The Board named the following officers: chairman, Dr. Hugh Hussey, Washington, D.C.; vice chairman, Dr. Percy Hopkins, Chicago, and secretary, Dr. James Z. Appel, Lancaster, Pa.

Named to the Judicial Council were Dr. Robertson Ward, San Francisco, to succeed himself, and Dr. Elmer G. Shelley, North East, Pa., to replace Dr. Pearson.

Re-elected to the Council on Constitution and Bylaws was Dr. Walter E. Vest, Huntington, W. Va.

New Members of the Council on Medical Service are Dr. Charles Ashworth, Providence, R. I., succeeding Dr. Carlton Wertz, Buffalo, N.Y., and Dr. Burtis E. Montgomery, Harrisburg, Ill., to succeed Dr. Charles Hudson, Cleveland.

For the Council on Medical Education and Hospitals, Dr. Dwight L. Wilbur, San Francisco, was elected to succeed Dr. John W. Cline of the same city, and Dr. Kenneth C. Sawyer, Denver, Colo., was named to succeed Dr. Guy A. Caldwell, New Orleans.

HAROLD C. OCHSNER, M.D.
E. S. JONES, M.D.
FRANCIS L. LAND, M.D.
GORDON B. WILDER, M.D.
WENDELL C. STOVER, M.D.

Reports of Committees

Executive

The Executive Committee met for the first time on Oct. 5, 1960 following the close of the final session of the House of Delegates. At this meeting, by ballot, Dr. Don E. Wood of Indianapolis, was elected chairman of the Executive Committee. Dr. Harry R. Stimson of Gary was welcomed to the committee by virtue of his office as president-elect and Dr. Irvin Wilkens of Indianapolis was welcomed to the committee as treasurer of the Association.

The secretary asked at this meeting for clarification of the action of the House of Delegates regarding the building fund and he was instructed that the dues receipts for the 1961 year should carry this item.

November 1, 1960 Meeting

The committee met at the home of Dr. Maurice E. Glock of Fort Wayne.

At this meeting it was reported that the Marion County Board of Review had granted the Association tax-exempt status from the payment of personal property taxes.

The chairman of the Commission on Legislation discussed the issues which would come before the 1961 State Legislature and plans were made for conducting the legislative program of the Association.

The 1960 annual convention was reviewed and it was agreed that in 1961 only one night of entertainment should be planned in order to give the members of the Association more free time during the annual meeting.

The committee also approved the suggestion made by Dr. Glen Ryan that the Association establish a bowling tournament as a part of the annual convention.

At this meeting also the convention dates were established as follows:

1961—October 24, 25 and 26, Indianapolis

1962—October 7, 8, 9 and 10, French Lick

1963—October 15, 16 and 17, Indianapolis

1964—October 11, 12, 13 and 14, French Lick

The committee took action not to participate in the 1961 Science Fair, feeling that the cost of the Association's participation had reached an item of major expense and it was felt this expense could be eliminated.

The committee referred to the Council a suggestion that the Blue Shield Plan be formally requested to forward to the Grievance Committee any claims which they received which indicated abuse of the plan.

The committee referred to the Commission on Medical Education and Licensure the study of a new student loan plan known as H. E. L. P., standing for Higher Education Loan Plan. The Executive Committee had been informed that this plan would afford the Association to loan \$12.50 for every dollar invested in the program.

The committee's response to a letter from Mrs. Helen Johnson, Associate Director, Nursing Services, Indiana University Center, named the following committee to represent the Association for consultation in planning short courses in nursing:

Glen W. Irwin, Jr., M.D., Indianapolis, chairman
Nathaniel D. Ewing, M.D., Vincennes
Glynn A. Rivers, M.D., Muncie
Harry E. Klepinger, M.D., Lafayette

The latest ruling of the Joint Commission concerning accreditation of hospitals with osteopaths on the staff and a letter from the American Medical Association regarding their position on this question were read for the information of the committee.

The attorneys reported on the litigation concerning the proposed building site for the Association headquarters office building.

A communication from the State Board of Accounts concerning the relationships between radiologists and hospitals was referred to the legal counsel for discussion with the State Board of Accounts.

A proposed letter* to the State Director of Public Welfare concerning implementation of a program to provide medical care for the aged and unofficially outlining the method used in administering the Medicare program was approved and the secretary was instructed to send copies to each member of the Executive Committee, the Council and the Commission on Governmental Medical Services.

Normal business of *The Journal* and Medical Defense was handled in the routine manner.

December 7, 1960 Meeting

The committee met on Dec. 7, 1960 at the Student Union Building in Indianapolis and the secretary reported the problems he was having with the collection of dues. This matter was referred to the Council.

The annual audit by the certified public accountants was reviewed by the committee and was approved.

The chairman of the Commission on Legislation reported on a letter from a member of the Association setting forth the danger the medical profession faces in signing absentee voter ballots.

It was also announced the Association had been formally requested to appear before the State Legislative Advisory Committee on Dec. 13 to discuss the Medical Association's opinion as to the implementation in Indiana of Public Law 778 of the 86th Congress, known as the Kerr-Mills Bill.

Plans for the annual meeting with the Indiana delegation in Congress were finalized at this meeting.

The committee received a letter from the Commission on Medical Education and Licensure with the request for the Executive Committee to reconsider its previous action on the Science Fair and to approve an amount up to \$3,000.00 to defray the transportation costs of the regional winners. The secretary reviewed the exchange of correspondence between the Association and Dean K. L. Kaufman of Butler University and the committee approved of this correspondence and reaffirmed its previous action not to participate in the 1961 Science Fair. This action of the committee was referred to the Council.

An outline of criteria to be used for the recognition of voluntary health agencies was received from the

Commission on Voluntary Health Agencies. The committee advised the Commission that it thought well of the ideas as expressed by the Commission.

Dr. Truman E. Caylor, a delegate to the White House Conference on Aging, was designated as the official liaison to represent the Association with the American Medical Association.

The committee received a report from the Commission on Public Health outlining its recommendations concerning ambulatory treatment of narcotic addicts in which the Commission recommended further study.

The committee approved attempting to obtain an option on the property immediately south of 3935 N. Meridian St., Indianapolis.

The chairman of the Executive Committee reported on the American Medical Association interim session and the activities of the officers and delegates during the meeting.

Other routine business concerning *The Journal*, Medical Defense and representatives to attend medical meetings were handled by the committee.

January 14, 1961 Meeting

The committee met at the I. U. Student Union Building, Indianapolis.

Financial and membership reports were reviewed and approved.

The Professional Corporate Practice Bill was reviewed by the committee and the committee is to recommend to the Council that the Association not support this measure. Also reviewed was proposed legislation from the Indiana State Hospital Association. National legislation was discussed and a letter from the President of the American Medical Association concerning the effort which organized medicine would have to put forth in the coming Congress when the question of expanding social legislation was discussed.

A letter from the Indiana State Dental Association stating they would like to cooperate with the Indiana State Medical Association in the implementation of the Kerr-Mills Bill in Indiana was read.

A letter from the American Medical Association commending the president for his interview as published in the *Criterion* was read.

A tentative outline of the 1961 scientific program was reviewed.

The committee decided not to name a representative to the National Foundation Scholarship Committee.

The committee approved the report of the Commission on Inter-Professional Relations that the Association approve an amendment to the rules and regulations of the Joint Committee on the Improvement of Patient Care.

The committee disapproved the request of a pharmaceutical firm to distribute samples of a publication in the News Flash.

The committee approved the proposal of a travel bureau to promote an European trip following the June meeting of the American Medical Association.

Other routine business was conducted by the committee in the field of matters pertaining to *The Journal* and Medical Defense.

February 4, 1961 Meeting

The Executive Committee met at the Hay Adams Hotel in Washington, D. C., for the transaction of its regular business and the financial and membership reports were reviewed and approved.

The committee approved the Building Committee formally purchasing the property located at 3935 N. Meridian St., Indianapolis, and empowered the committee to proceed in the taking of bids for the construction of the headquarters office building. The secretary is instructed to send a breakdown to each county medical society showing the membership and the contributions to the building fund as of March 1.

The chairman of the Commission on Legislation reported that several members of the Association, representing certain groups in the state, were supporting the Corporate Practice Bill in opposition to the position taken by the Association. After further reviewing this matter, the committee voted that the Association is still opposed to passage of this type of legislation.

The chairman of the Commission on Legislation also discussed the planning of the breakfast to be held with the Indiana delegation the following morning.

Other routine matters including the appointment of Dr. Charles F. Gillespie of Indianapolis to the Maternal Mortality Study Committee, information concerning 300 exiled Cuban physicians in Miami looking for employment, the announcement of Merck, Sharpe & Dohme in which they had presented to the State Department of Public Welfare the offer of a 10% discount on all their products prescribed for welfare recipients, were reviewed.

Also reviewed was a letter from the Michigan State Medical Society suggesting that the midwestern states have a meeting for the purpose of discussing a uniform procedure on the transfer of membership, a transmittal from the Commission on Constitution and Bylaws, a letter from the Director of the Division of Public Health Nursing of the Indiana State Board of Health, a letter from C. Philip Fox and several letters addressed to CBS concerning the telecast on "The Business of Health," were reviewed by the committee. In addition several matters dealing with the Medicare program, *The Journal* and future meetings were reviewed.

March 29, 1961 Meeting

The committee convened at the Student Union Building in Indianapolis and the financial transactions of the headquarters office and *The Journal* were reviewed.

The renewal of the Blue Cross and Blue Shield contract covering the headquarters employees was approved the contract for the wrecking of the building at 3935 N. Meridian St. was signed and a review of the number of members who had paid into the building fund was made.

The secretary asked for instructions concerning the administering of refunds on building fund certificates. The secretary also called to the attention of the committee that the Council, at its meeting in January, failed to establish a cut-off date for refunding voluntary building fund contributions and the committee took action to recommend to the Council that it establish such a cut-off date and also determine the question as

to whether or not a mandatory payment to the building fund is to be enforced for new members.

The first quarter audit by the certified public accountants was reviewed and approved.

The chairman of the Commission on Legislation reviewed his report made to all societies on the action of the State Legislature and the attorneys discussed the meaning and effect of S. B. 436. This matter was referred to the Council for its next meeting.

Other routine matters coming before the committee were disposed with in orderly fashion.

April 8, 1961 Meeting

The committee met at the Student Union Building in Indianapolis and the financial transactions of the headquarters office for the prior period were reviewed and approved.

The treasurer was instructed to investigate the possibilities of investing some of the surplus funds of the Association in building and loan associations.

Mrs. E. L. Rigley, president of the Woman's Auxiliary, appeared before the committee for a review of the program of the Auxiliary and a review of the financial status of the Auxiliary. The committee approved a subsidy to the Auxiliary in meeting their financial obligations and at the same time recommended to the Auxiliary that they seriously consider raising their dues to carry on their program.

Dr. Ralph Everly, chairman of the Building Committee, appeared before the committee for a report on the status of the building program.

The chairman of the Commission on Legislation reviewed the legislation currently before the Congress and discussed plans for the Executive Committee to meet in Washington, D. C., on May 1, 2 and 3.

Other normal routine matters were disposed with by the committee.

April 30, 1961 Meeting

The Executive Committee convened at the Mayflower Hotel in Washington, D. C., and the review of the membership and financial transactions for the previous period were approved.

A written report from the chairman of the Building Committee was received and the treasurer's recommendation for the investing of some of the surplus funds of the Association in building and loan associations was approved.

The Chairman of the Commission on Legislation reviewed the national legislative picture and the plans of visitation by the members of the Executive Committee with various members of the Indiana delegation in Congress during the stay of the committee in Washington.

A letter from Dr. Owsley concerning a request to be made to Circuit Court judges that they appoint a physician as a member of the local welfare board was referred to the Council.

A letter from the legal firm of Dowden, Denny, Caughran and Lowe addressed to the Indiana Hospital Association concerning proposed changes in the hospital bylaws was referred to the Commission on Medical Education and Licensure for study and report.

Many other routine matters were disposed with by the committee.

June 14, 1961 Meeting

The committee convened at the Columbia Club in Indianapolis on June 14 for the transaction of the regular routine business and for other matters requiring the decision of the committee.

The membership report and the financial status of the Association were reviewed and approved.

The secretary was authorized to purchase a new typewriter for the headquarters office.

The committee took action to recommend to the Commission on Constitution and Bylaws that the Bylaws be amended in such a way that no expenditure of Association funds not included in the budget shall be made without the appropriating body first determining where the money is to come from.

The committee was informed that there was a possibility that the House Ways and Means Committee would hold public hearings on H. R. 4222. By consent it was agreed that the Association should request time and that Dr. Don E. Wood should appear before the committee.

Other organizational matters were brought before the committee, one of which was a recommendation to split the Seventh District Medical Society into two districts, and this was to be referred to the Council.

The secretary was instructed to offer the assistance of the headquarters office to the specialty groups in arranging their respective programs.

Matters relating to the 1961 convention were discussed and it was voted to request Dr. Herman M. Baker of Evansville to serve as chairman of the reception for the Fifty-Year Club and to request Dr. Karl Ruddell to make the response on behalf of these members.

Members of the Building Committee met with the Executive Committee at this time and reported that the lowest bid received was some \$144,000.00 higher than the budgeted amount and it would be necessary to re-analyze the plans of the building to see if construction could be obtained within the budgetary limits.

July 8, 1961 Meeting

The committee convened at the Student Union Building in Indianapolis at which time the Building Committee met with the Executive Committee for a discussion of the building problems. The Building Committee presented a resolution which in effect authorized them to negotiate the contract for a building with Thomas A. Berling & Sons, Inc., who was the lowest bidder, for the construction of a building, the cost not to exceed \$276,000.00. This resolution was accepted by the Executive Committee who in turn adopted a resolution empowering the Building Committee to proceed with the construction of a building at this price and to enter into a contract with Thomas A. Berling & Sons, Inc., contractors.

The report of the statement of income, expenditures, and budget balances of the headquarters office, *The Journal* and the building fund, along with the auditor's third-quarter audit, was reviewed and approved by the committee.

The secretary reported on the fact that he had transmitted \$2,000.00 to a member of the Association as approved by the Council for the Science Fair but as yet had received no report to how the money was spent. The entire matter was referred to the Council.

Several routine matters concerning legislation and the organization came before the committee and were expeditiously handled.

A discussion was held concerning the operation of the Association officers and delegates during the American Medical Association meetings and the committee referred to the Council several matters including the authorization to prepare a manual outlining the responsibilities and procedures to be followed by the AMA delegates, that the Council should also approve the payment of expenses of sending the alternate delegates to the AMA meetings and that the AMA delegates and alternates be requested to meet with the Executive Committee at it meeting immediately prior to each session of the AMA.

It was also agreed to refer to the Council a request for the authorization to employ an assistant to the Executive Secretary.

The letter from the Blue Cross Plan notifying Indiana physicians that they would be required to reconfirm hospital stays on Blue Cross patients for more than 15 days with the plan, otherwise payment would not be made, was discussed and the matter was referred to the Council with the recommendation that physicians of Indiana be instructed to ignore the directive.

Notice of the election of Dr. Frank B. Ramsey, editor of *The Journal*, to the Advisory Board of the State Journal Advertising Bureau was announced and approval was given to the Executive Secretary to participate as a chairman of a session during the annual meeting of the State Journal Advertising Bureau.

Also noted was the election of the Executive Secretary as secretary-treasurer of the Conference of Presidents and Other Officers of State Medical Associations.

At the time of writing this report in order to make publication deadlines, it is not possible to report on the August and September meetings of the committee. However, complete minutes of these meetings as well as complete minutes of all meetings held during the year will be given to the Reference Committee for its review.

Don E. Wood, M.D., *Chairman*

Medical Defense Activities

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1960, the following seven cases were pending before the committee, three of which were closed during the year, leaving four cases still pending:

- Case No. 251—Filed Sept. 25, 1942. Pending.
- Case No. 288—(Closed.) Filed Nov. 12, 1954. Disposed of in Superior Court in 1956; plaintiff appealed case and won on appeal. Settled Jan. 1961, by defendant. (Expense, \$270.00, paid Sept. 12, 1956, and \$172.50, paid May 23, 1957.)
- Case No. 296—Filed April 9, 1957. Pending. Plaintiff has died so case probably will be dismissed by the court.

- Case No. 298—(Closed.) Filed Jan. 31, 1958. Settled Sept. 23, 1960. Expense, \$394.92.
- Case No. 300—(Closed.) Filed June 18, 1958. Settled Dec. 22, 1960. Expense, \$300.00.
- Case No. 301—Filed 1951. Pending.
- Case No. 302—Filed July 30, 1957. Pending.

Since Aug. 1, 1960, and up to Aug. 1, 1961, no new cases have come before the committee; four cases are therefore pending at the present time as against seven unclosed cases a the same time last year. Several threatened suits have been reported to the headquarters office but formal applications for medical defense by the Indiana State Medical Association have not been filed up to this time.

2. *Medical Defense Fund Statement from Aug. 1, 1960 to Aug. 1, 1961:*

Balance, Aug. 1, 1960.....	\$ 3,993.25	
Receipts:		
Dues 1960 members	\$ 27.50	
1961 members	4,909.00	
		\$ 4,936.50
Interest on bonds	592.00	
Matured Treasury Bills	12,000.00	
		17,528.70
Total Receipts		\$21,521.95
Disbursements:		
Malpractice fees	\$ 694.92	
Attorneys' salaries	2,790.00	
Paid to Indiana State Medical Association for prior year's obligations.....	1,778.31	5,263.23
Purchase of U. S. Treasury Bills.....	\$12,000.00	
Less discount on U. S. Treasury Bills	75.36	\$11,924.64
Total Disbursements		\$17,187.87
Balance, August 1, 1961.....		\$ 4,334.08

Membership Report

	Dec. 31, 1960	July 31, 1960	July 31, 1961	Delinquent 1961	A.M.A. 1961
1st District					
Gibson	17	17	15		14
Perry	12	12	13		13
Pike	5	5	4		4
Posey	11	11	11		11
Spencer	6	6	6		5
Vanderburgh	214	214	230		223
Warrick	12	12	12		13
TOTAL	277	277	291		283
2nd District					
Daviess-Martin	22	22	20		19
Greene	16	16	16		8
Knox	43	43	43		41
Owen-Monroe	54	53	53		51
Sullivan	16	16	16		14
TOTAL	151	150	148		133
3rd District					
Clark	33	32	33		33
Dubois	22	22	23		20
Floyd	38	38	40		40
Harrison-Crawford	14	14	14		14
Lawrence	27	27	28		26
Orange	10	10	9		9
Scott	4	4	3		3
Washington	7	7	7		7
TOTAL	155	154	157		152

	Dec. 31, 1960	July 31, 1960	July 31, 1961	Delinquent 1961	A.M.A. 1961		Dec. 31, 1960	July 31, 1960	July 31, 1961	Delinquent 1961	A.M.A. 1961
<i>4th District</i>						<i>12th District</i>					
Bartholomew-Brown	38	38	44		43	Adams	15	15	15		15
Dearborn-Ohio	19	19	19		18	Allen	264	263	263		262
Decatur	13	13	12		9	DeKalb	20	20	22		19
Jackson	20	20	17		14	La Grange	8	8	9		8
Jefferson-Switzerland	24	24	27		25	Noble	20	20	18		17
Jennings	9	9	9		7	Steuben	13	13	15		15
Ripley	9	9	9	1	7	Wells	33	33	30		30
TOTAL	132	132	137	1	123	Whitley	17	17	17		17
						TOTAL	390	389	389		383
<i>5th District</i>						<i>13th District</i>					
Clay	14	13	12	1	12	Elkhart	107	105	105	1	102
Parke-Vermillion	24	24	23	1	23	Fulton	10	10	9		9
Putnam	16	16	16		16	Kosciusko	17	17	17		17
Vigo	120	119	113	1	114	LaPorte	92	92	95		93
TOTAL	174	172	164	3	165	Marshall	23	23	22	1	22
						Pulaski	8	8	7		6
<i>6th District</i>						St. Joseph	231	227	227	3	226
Fayette-Franklin	19	19	18		18	Starke	6	6	6		6
Hancock	22	22	21		21	TOTAL	494	488	488	5	481
Henry	44	44	46		46						
Rush	16	16	15		15						
Shelby	18	18	18	1	18						
Wayne-Union	77	77	75		69						
TOTAL	196	196	193	1	187						
						SUMMARY					
<i>7th District</i>						1st District	277	277	291		283
Hendricks	21	21	19		19	2nd District	151	150	148		133
Johnson	33	30	32		32	3rd District	155	154	157		152
Marion	1074	1072	1078	2	1075	4th District	132	132	137	1	123
Morgan	17	17	16		16	5th District	174	172	164	3	165
TOTAL	1145	1140	1145	2	1142	6th District	196	196	193	1	187
						7th District	1145	1140	1145	2	1142
<i>8th District</i>						8th District	255	250	247	9	232
Delaware-Blackford	108	105	105	3	102	9th District	248	246	250	1	243
Jay	16	16	16		14	10th District	455	435	454	5	425
Madison	108	106	104	6	100	11th District	237	237	235	5	229
Randolph	23	23	22		16	12th District	390	389	389		383
TOTAL	255	250	247	9	232	13th District	494	488	488	5	481
						TOTAL	4309	4266	4298	32	4178
<i>9th District</i>											
Benton	9	9	9		8						
Boone	20	20	18		19						
Clinton	20	20	20		20						
Fountain-Warren	15	15	15		15						
Hamilton	24	24	24		16						
Montgomery	30	29	28	1	28						
Tippecanoe	108	107	114		115						
Tipton	11	11	11		11						
White	11	11	11		11						
TOTAL	248	246	250	1	243						
<i>10th District</i>											
Jasper-Newton	14	14	12		12						
Lake	416	396	414	5	385						
Porter	25	25	28		28						
TOTAL	455	435	454	5	425						
<i>11th District</i>											
Carroll	10	10	10		10						
Cass	42	42	41	1	40						
Grant	65	65	67		66						
Howard	53	53	55		55						
Huntington	22	22	22		21						
Miami	21	21	15	4	15						
Wabash	24	24	25		22						
TOTAL	237	237	235	5	229						

The Journal

Advertising

This is a comparative report for the first six months of each year indicated.

State Journal				
Advertising	1958	1959	1960	1961
Bureau	\$29,253.57	\$40,978.58	\$33,314.83	\$23,697.85
Sold Direct				
by Journal	2,692.19	3,083.18	2,501.98	1,976.08
Total	\$31,945.76	\$44,061.76	\$35,816.81	\$25,673.93

Printing Cost

Year	Cost	No. of Pages (Inserts excluded)
1957	\$46,211.34	1920
1958	50,093.16	1872
1959	63,841.30	2243
1960	62,679.13	2222
1961 (6 months)	23,286.09	940

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Adv. Pages per Issue
1956	890	53	782	47	1672	139.3
1957	910	51	862	49	1772	147.7
1958	1055	52	969	48	2024	169
1959	1226	53	1088	47	2314	192.9
1960	1413	61	919	39	2332	194

EXECUTIVE COMMITTEE

DON E. WOOD, M.D., *Chairman*
 WENDELL E. COVALT, M.D.
 GUY A. OWSLEY, M.D.
 HARRY R. STIMSON, M.D.
 MAURICE E. GLOCK, M.D.
 IRVIN W. WILKENS, M.D.

Grievance

The Grievance Committee met Oct. 5, Nov. 13, 1960 and Aug. 13, 1961. The chairman of the committee reported its business at each meeting of the Council of the Indiana State Medical Association.

Fourteen of the 18 cases which the ISMA Committee had accepted for adjudication in 1959-60 were closed. The Grievance Committee thus far in 1961 has accepted eight complaints, one of which has already been satisfactorily settled.

Fewer meetings were necessary due to the evolution of an improved communication system with the physicians concerned, and an increasing acceptance of cases for adjudication by the county medical societies for which the ISMA Committee has worked and now expresses its appreciation.

The most important continuing item of business for this Committee resulted from the assignment given by the 1960 House of Delegates as to a state-wide study of medical discipline. It had been hoped that the AMA Medical Disciplinary Committee could report its nation-wide study early in 1961. This report was not made available until June, 1961, following the AMA House of Delegates meeting.

After circulation and study of the AMA report, the Grievance Committee met on Aug. 13, 1961 to consider the specific recommendations not anticipated and not already effective for ISMA. A supplementary report on this matter will apparently be required for the 1961 ISMA House of Delegates meeting.

PHILIP B. REED, M.D., *Chairman*
 RAYMOND E. NELSON, M.D., *Vice-Chairman*
 GEORGE L. DERHAMMER, M.D., *Secretary*
 WILLIAM H. GARNER, SR., M.D.
 LLOYD C. MARSHALL, M.D.
 H. ALLISON MILLER, M.D.
 LOWELL H. STEEN, M.D.
 M. C. TOPPING, M.D.
 PAUL L. STIER, M.D.
 RUSSELL J. SPIVEY, M.D.

Student Loan

Following is a report on the Student Loan Fund since it was established by the House of Delegates in October, 1955, up to and including July 31, 1961:

Transfer of Funds from the General Fund, as authorized by the House of Delegates:

May 6, 1956	\$10,000.00
May 3, 1957	5,000.00
January 16, 1959	5,000.00
Oct.-Dec., 1960	8,800.00
Jan.-July, 1961	11,200.00

TOTAL	\$40,000.00
Payments on notes	7,632.68
Interest on notes	253.14
Miscellaneous Income:	
Memorial donations	\$ 26.00
Donations from E. S. Jones, M.D.	217.03
Interest on U. S. Treasury Bills	270.51
	513.54

TOTAL RECEIPTS	\$48,399.36
Expenditures:	
Printing of application forms, notes and checks	\$ 211.54
Loaned to students	46,858.36

TOTAL EXPENDITURES	\$47,069.90
BALANCE IN FUND, JULY 31, 1961	\$ 1,329.46

A total of 106 loans have been granted to 90 students;
 14 students have received 2 loans each;
 1 student has been granted 3 loans;
 75 students have received 1 loan each.

As of July 31, 1961, 12 recipients of loans have repaid their loans in full. Seven additional loanees have made partial payments.

The interest rate on loans made prior to Oct. 15, 1958, is 3½%; starting October 15, 1958, the rate was increased to 6% by the House of Delegates. In October, 1960, the House of Delegates authorized a 2% interest rate. Loans do not bear interest until the student has completed his internship.

HARRY PLUMMER ROSS, M.D., *Chairman*
 GUY A. OWSLEY, M.D.
 JOHN D. VAN NUYS, M.D.
 JAMES O. RITCHEY, M.D.
 LESTER D. BIBLER, M.D.
 IRVIN W. WILKENS, M.D.

Reports of Commissions

Legislation

The Commission on Legislation was quite active this past year because of the General Assembly in January 1961. The first meeting was conducted in October immediately following the state convention, at which time Drs. Donald Wood and Walter Portteus were elected chairman and co-chairmen of this commission. Almost weekly meetings were held during the months of January, February and up to March 6, at the time the General Assembly retired. Practically all of the bills that were supported by your commission passed. Only three bills actually that were opposed passed and two of these are relatively insignificant. One of these bills, Senate Bill 436, will probably be of some significance. This bill allows osteopaths to practice in county hospitals supported by federal funds. Certainly this bill must await some more protracted legal opinion before its full import will be known.

Senate Bill 221 is of significance because this bill is the implementing measure in support of the Kerr-Mills Bill. This particular bill allows a federal, state and county matching-type of program to take care of those in need of medical care who cannot afford this care. This bill, of course, was the Eisenhower administration's answer to the Forand Bill type of legislation.

Looking into the future one could use the words of Sen. Kerr, who very aptly stated at a Chicago meeting in March that, "the doctors have won the battle but not the war." We are now faced with the King-Anderson Bill which is much like the Forand Bill except it excludes compensation for the physicians. This commission is quite well aware of its responsibility and job in the coming year regarding this measure.

Special commendation should go again to those men on this commission who live in and around Indianapolis and have been so generous of their time concerning this commission and this responsibility.

DON E. WOOD, M.D., *Co-Chairman*
JOSEPH M. BLACK, M.D., *Co-Chairman*
EUGENE F. SENSENY, M.D., *Secretary*
P. J. V. CORCORAN, M.D.
ROBERT O. BETHEA, M.D.
DONALD KERR, M.D.
LESLIE M. BAKER, M.D.
JOSEPH WEBER, M.D.
PAUL R. TINDALL, M.D.
JOHN W. HENDRICKS, M.D.
PAUL T. LAMEY, M.D.
LEE J. MARIS, M.D.
PHILIP ROSENBLUM, M.D.
DONALD K. WINTER, M.D.
OTIS BOWEN, M.D.

Public Information

The purpose of the Commission on Public Information is to collect and organize for dissemination to the public all matters of public interest within the field of

medicine, including the activities of other commissions in which the public interest would be involved, and including the achievements in the advancement of medicine which would be of interest to the public, to develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

The activities of the commission during the past year are hereby summarized.

I. Public Relations

A state-wide level Conference on Public Relations is to be held immediately prior to the annual ISMA meeting on Oct. 23. The program committee is winding up its successful search for subjects and participants which will insure every visiting member a most eventful day.

The committee approved the suggestion of the recommendation that the ISMA put on a retainer basis a public relations counselor.

The committee agreed as to the importance of the medical profession taking the initiative and playing a leading role in the polio vaccination program.

II. Liaison Committee with the AFL-CIO

The Council, in 1960, approved the reestablishment of a liaison committee between the medical profession and the AFL-CIO. Our commission accepted this responsibility. A committee of three physicians met with the AFL-CIO group in July, 1960, to discuss mutual problems and yearly meetings are being arranged.

III. Health Hints—Radio and T.V.

The column, "Health Hints" was distributed to approximately 200 Indiana newspapers, as in the past. The field secretaries have called numerous newspaper editors and several newspapers have been added to the list of those printing "Health Hints" on a weekly basis. These columns are all reviewed by members of the commission for corrections or additions prior to publication.

County medical societies have received lists of available radio transcripts that can be used by radio stations in their respective areas. Many of the county societies have used these programs as part of their public relations activities.

It was called to the attention of the officers and councilors of the State Medical Association the success of the television program, "Ask Your Doctor," sponsored by the Public Relations Committee of the Marion County Medical Society. This program has been on the air since April, 1955, and has been continuous except for the seasonal cessations during the summer months. Panel discussions of common health disorders by three physicians are taped and presented on T.V. Sunday afternoon. The response has been most gratifying as determined by the numerous telephone calls and letter inquiries. It was suggested to the councilors and officers that similar programs could be conducted by

our district medical officers at various television centers throughout our state.

"Doctors' House Call," a nationally-syndicated radio series, is being considered by our commission as material to be presented for local sponsorship to our state radio stations. This program is a tape inventory, summarizing some two hundred and sixty three minute health education messages which have been presented with great success in Minnesota.

IV. Science Fair

Continued participation in Science Fair activities including the defraying of expenses of local representatives to the National Science Fair is most desirable.

V. State Fair Exhibits

The commission, with the assistance of the AMA Bureau of Exhibits, is presenting exhibits that are currently in the public eye, namely: "Your Glands."

Members of the Woman's Auxiliary of the Marion County Medical Society will serve as attendants to these exhibits and medical students will be available to record blood pressure readings of visitors who wish such.

VI. Medical Assistants Program

Indiana University, through its extension centers, is conducting a training program for medical assistants. The program consists of a non-credit college level course consisting of six subjects and is given one night weekly. The commission is furthering this program by giving it adequate publicity and support.

WILLIAM G. BANNON, M.D., *Chairman*
HARRY G. BECKER, M.D., *Vice-Chairman*
THOMAS D. ARMSTRONG, M.D., *Secretary*
R. L. KLEINDORFER, M.D.
GLEN McCLURE, M.D.
B. E. SUGARMAN, M.D.
HARRY R. BAXTER, M.D.
WILLIAM R. TINDALL, M.D.
SETH ELLIS, M.D.
JAMES M. KIRTLEY, M.D.
FRANKLIN F. PREMUDA, M.D.
RUSSEL M. HUMMEL, M.D.
N. H. GLADSTONE, M.D.
RICHARD W. HOLDEMAN, M.D.
A. ALAN FISCHER, M.D.

Governmental Medical Services

The organizational commission meeting was held immediately following the annual session at French Lick, Indiana. At this time, officers were elected and sub-committees formed. There has been considerable activity in all the commission work during the past year.

The committee report is broken down into subdivisions covering those subjects assigned to your Commission:

Medicare

The MEDICARE program is a program which incorporates a contract between the Defense Department of the United States Government and your Indiana State Medical Association to provide medical and surgical care under certain prescribed categories for the dependents of personnel in the active military service. This program is administered by a special subcommittee of the Commission on Governmental Medical Services. This committee has met several times during the past year in conjunction with the commission as a whole. Also the individual members of the committee are at work constantly processing the claims sent in by Indiana physicians for services rendered under the plan.

The program began July 1, 1957. The following is a statistical resume of this program up to Jan. 1, 1961:

Year	Number of Claims	Total Amount Paid	Average
1957 (6 mo.)	2859	\$218,428.52	\$76.39
1958	5984	460,879.62	77.01
1959	5098	419,782.98	82.34
1960	5068	396,399.98	78.28
3½ total	19009	\$1,495,399.12	\$78.67

The above will give one an idea of the volume of work done under this plan. It will be noticed that the number of claims dropped sharply in 1959 in comparison year. This was due to the curtailment of the amount of work allowed by the contract, but the next year these curtailments were done away with and the original scope of the allowable work was restored. However, the number of claims have not yet again reached the average of 1957 and 1958.

Civil Defense

The sub-committee was again represented at Chicago at the Eleventh County Medical Societies' Conference on Disaster Medical Care, Nov. 4-6, 1960. Dr. Edward Teller, Ph.D., spoke on "The Physicians Role in Nuclear Disaster." Dr. Teller favored family and public shelters. The various states conducted Workshop Sessions on problems of Medical C. D., and three other good papers read. Members of this committee also attended the annual C.D. meeting preceding the recent AMA meeting.

A Fall C.D. meeting is being planned which probably will be held in Rice Auditorium of the State Board of Health Building. This meeting will be for doctors, dentists, nurses, veterinarians, hospital administrators, etc., and we hope to have an excellent program.

The commission recommends that all members of Indiana State Medical Association become active in the disaster preparedness program.

Mental Health

Effective July 1, the Northern Indiana Childrens' Hospital was transferred to the Department of Mental Health and will hereafter be administered as a branch of the Fort Wayne State School. This will provide approximately 150 beds for mentally retarded children and will somewhat relieve the backlog of approximately 800 children awaiting admission to Muscatatuck and the

school at Fort Wayne. It has been requiring approximately three years to secure admission after a mentally-defective child was placed on the waiting list. The last legislature recommended that five centers for the treatment for emotionally disturbed children were needed but no money was appropriated for their establishment.

The last legislature appropriated an additional \$10,-000,000 to mental health but this will, for the most part, cover only the cost for converting to a 40-hour week for personnel in the institutions. The conversion to the 40-hour week was also passed by the legislature. However, our seven mental institutions, if they were fully staffed to authorized strength, would be short of a total of \$400,000 to put the 40-hour week into effect. On top of this the Governor has ordered a five percent cut overall on state employee personnel to become effective Jan. 1, 1962 because of estimated shortage of state funds available.

The Family Care budget has been increased. This should permit approximately 75 patients to be placed in private homes and nursing homes, and thus gotten out of our state institutions.

Funds for local mental health clinics were also increased. This year \$350,000 was available; next year the amount will be \$400,000 and in 1963, \$500,000, for a total of \$900,000 for the biennium. Thirty thousand dollars was appropriated for local clinics for alcoholics. More local mental health clinics are continually being established or proposed and county medical societies are urged to have members on their boards and to assist in developing the plan of operation.

Dr. Kime of the State Anatomical Board has requested the State Mental Institutions to cooperate by furnishing bodies because of various governmental funds for the purpose of burial available to families, few bodies remain unclaimed.

There was consideration in the last legislature toward making business administrators the superintendents of state mental institutions in place of chief psychiatrists who now are the hospital administrators. This would be contrary to the recommendation of the AMA and any future moves in this direction should be resisted by our State Medical Association.

During the past year the State Medical Association has continued to act as co-sponsor, together with State Hospital Association, the Indiana Division of Mental Health, the State Nurses' Association and the Tri-Kappa Sorority, to conduct clinics to train graduate nurses in the care of acute mentally-ill patients.

The Tri-Kappa Sorority is to be commended for their continuing interest in this field and particularly for their program which raises funds to underwrite the complete cost of these activities.

War Manpower

No problems referable to War Manpower nor to the drafting of doctors have been referred to the committee this year.

Liaison with the State Department of Public Welfare

There has been considerable activity between the Indiana State Medical Association and the Department of Public Welfare of the State of Indiana during the

past year. We have had several joint meetings with the director concerning problems affecting both of our groups. There has been considerable variance throughout the state as to the welfare schedules of medical payment and this has been a source of considerable discussion. There has been contact made with some of the counties involved and we feel that the close liaison we have had with the Department of Public Welfare will benefit all involved.

It is planned to continue the close liaison, particularly since the enactment of the legislation in the last General Assembly which involves the implementation of Kerr-Mills Bill. As you know, this was placed under O.A.A. or the Old Age Assistance Program, and, therefore, comes under the same requirements as does the medical payments to the old age group who are now covered by welfare payments. It is not felt that there will be a great amount of activity under this one portion of the Welfare Department.

Liaison Committee on Veteran's Affairs

There have been quarterly meetings of this group involving the American Legion, Indiana State Dental Association, Indiana Hospital Association and the Indiana State Medical Association. All the main problems have been discussed during the meeting. There have been no definite decisions, or any need for such, since this is actually a sounding board for all groups. It is, also, used to help in legislative matters where the four groups involved can be beneficial and helpful to each other. It is recommended that membership in this liaison group be continued.

CHARLES R. ALVEY, M.D., *Chairman*
JEAN V. CARTER, M.D., *Vice-Chairman*
GEORGE WILLISON, M.D., *Secretary*
JACK MCKITTRICK, M.D.
IRVIN E. HUCKLEBERRY, M.D.
HERMAN J. ECHSNER, M.D.
V. EARLE WISEMAN, M.D.
GLEN WARD LEE, M.D.
ARVINE POPPLEWELL, M.D.
ROBERT E. WILLIAMS, M.D.
HARRY R. STIMSON, M.D.
THEODORE J. BRUEGGE, M.D.
GEORGE D. BUCKNER, M.D.
JAMES M. WILSON, M.D.
STANLEY W. BURWELL, M.D.

Public Health

The Commission on Public Health had its first meeting of the year Oct. 5, 1960, for organization.

The following officers were elected: Emmett B. Lamb, M.D., Chairman, Richard C. Swan, M.D., Vice Chairman and Forrest J. Babb, M.D., Secretary.

The anticipated work for the commission was discussed and it was evident that there would be about the same general field of activity.

During the year, meetings of the commission and its committees were held, as seen necessary and practical.

Considerable emphasis was placed upon the Committee on Rural Health, especially in consideration of Rural Health programs and the Junior-Senior Medical Student

Day. It was also evident that considerable work would need to be done in the field of preventive medicine in collaboration with some of the governmental medical health agencies and the State Board of Health, with particular attention to the vaccination programs, tuberculosis control and the question of ambulatory treatment of narcotic addicts.

In further consideration of the year's activities, the following committees were appointed: Rural Health and Physician Placement, Industrial Medical Practices and Programs, Conservation of Hearing and Vision, Preventive Medicine and Liaison with State Board of Health and Traffic Safety.

The following are the specific reports from these special committees:

Rural Health

This committee's most important contribution to the Indiana State Medical Association was the Junior-Senior Day which was held at the Columbia Club on March 25, 1961. At this meeting the juniors and seniors of the local medical school were entertained in the afternoon with a program concerning the ethics, the finances, and the economics of the practice of medicine. Two members of the committee appeared on a panel for general practice. It was felt by the committee since this was assigned to the Rural Health Committee that encouragement should be given to the students for the rural practice of medicine. During this entire session they were encouraged to seek out rural areas for their practice. The role of the rural practitioner was placed in its true perspective. It was indeed enlightening to hear the questions asked. It was also brought out rather definitely by the students that our own medical school fails to encourage men in the general practice of medicine. It is felt by most of these students and learned from them in the past two years that the general practice of medicine in rural areas is actually discouraged.

This committee also met with the representatives of the Indiana Heart Foundation concerning the Purdue Cardiac Farm Study. It was felt by the committee that this study had not progressed to the point where it was ready for presentation to the medical profession as a useful tool.

The chairman of this committee attended the Rural Health Conference in Chicago held by the American Medical Association. While much material was gleaned from this meeting concerning the needs of rural health, it would seem that the American Medical Association chose poorly when they selected students to represent medical students. None of the students chosen to talk before these rural groups intended to do a rural practice. This seemed to be a glaring error in the program. It also would seem well that at their next program they be ready to answer the question why one opposes attachment of medical services to the Social Security Act rather than bypass it for as long as one day.

The physician procurement service operated by the office of the Indiana State Medical Association has continued to function without action nor participation of the members of this committee. We wish to thank Mr. Waggener and his staff for this fine cooperation.

The chairman wishes to thank the members of his committee for their diligent service and devotion to the causes herewith given.

EUGENE S. RIFNER, M.D., *Chairman*

Industrial Medical Practices and Programs

The Committee on Industrial Health spent the greatest part of its time meeting with the entire commission attempting to develop a program for Tuberculosis Control in Indiana, and in addition, considered ambulatory treatment centers for drug addicts, polio vaccine and Junior-Senior Medical Student Day.

The committee observed closely the Acts of the Indiana Legislature of 1961. No significant changes were made in the Workman's Compensation Law.

Committee counseled with small industries concerning the development of new medical programs. Problems relating to occupational health were reviewed with interested members of the Society.

The committee members have been quite active in national medical and nursing occupational health organizations and their program.

RICHARD C. SWAN, M.D., *Chairman*

Conservation of Hearing and Vision

There was a re-evaluation of silver nitrate treatment for the eyes by the committee in the light of newer antibiotics; it was the unanimous opinion of the committee that the standard, present method be continued until further information and evidence was available.

The Indiana Lions' Eye Bank as it has been organized was brought to the committee for review and a request for approval. This was carefully reviewed and it was recommended that the Commission on Public Health should convey to the Council a request for a Resolution that this program in its present structure at the Indiana University Medical Center be approved. This was carefully reviewed by Dr. Daniel Hare, of Evansville.

FORREST J. BABB, M.D., *Chairman*

Preventive Medicine and Liaison with State Board of Health

The Committee on Preventive Medicine and Liaison with the State Board of Health held one brief meeting with only Dr. John B. Hickam present prior to one of the commission meetings. We also met with members of a Committee on Voluntary Health Agencies, representatives of the Indiana Tuberculosis Association and the State Board of Health, at which the tuberculosis problem in Indiana was discussed. Following this another similar meeting was held when our committees prepared recommendations on the tuberculosis problem, to be presented to the Council of the Indiana State Medical Association. The outcome of this has not so far been announced to the commission and no further action has been taken although the groundwork presumably has been laid.

The second question turned over to the committee was the question concerning clinics for the ambulatory treatment for narcotic addicts. At the last meeting of our commission, Dr. Owsley said this was no longer an issue and that recommendations would not be required.

The third question concerned a resolution asking that rules and regulations for the use of the Sabin oral poliomyelitis vaccine be made for the consideration of the Association. The committee felt that recommendations to the physicians of the State rather than rules and regulations be made whenever sufficient information concerning the oral vaccine became available to make such recommendations. In the meantime the Committee felt that it should recommend that physicians generally make an effort to have their patients avail themselves of the Salk vaccine. Neither the committee nor the State Board of Health at present appears to be prepared to present recommendations for the use of the Sabin vaccine. Should such information become available this summer the committee will consider recommendations to be presented to the commission for their consideration.

GERALD F. KEMPF, M.D., *Chairman*

Traffic Safety

Following the commission organizational meeting Oct. 5, 1960, appointments to the Traffic Safety Committee were made.

At the meeting of Nov. 6, 1960, it was also agreed that a place on the program of the Indiana State Medical Association should be requested. This was done through James Waggner, Executive Secretary of our Association, who reported back that all time on this year's program was filled; however, time would be considered in 1962.

Since we found it very difficult to do original work within our Association the Commission on Public Health voted, at its meeting Jan. 8, 1961, to contribute \$100 to the Indiana Foundation for Traffic Safety. This recommendation was rejected by the Council of the Indiana State Medical Association at its meeting on Sunday, Jan. 15, 1961.

The Committee on Traffic Safety, at this time would like to call to the attention of the members several facts—

1. The death rate from auto accidents in the United States has stabilized between 38,000 to 40,000 per year; however, the injury rate finally reached 3,000,000 per year in 1960.

2. 80% of these accidents occur on dry roads in clear weather and 80% are caused by driver error.

3. As doctors we have done very little towards better driver education, seat belts, etc., but, according to Travelers Insurance Company, "the fact that deaths have not risen sharply in recent years is due largely to better and more prompt medical care."

To each of you we say thanks and keep up the good work.

HOWARD T. HAMMEL, M.D., *Chairman*

Conclusion

The Commission on Public Health would recommend that the same organizational structure be continued for the coming year.

We would recommend further careful consideration and frequent reviews of the vaccination programs, making every effort to get information of developments

to the membership of the Indiana State Medical Association.

It is further recommended that the program on rural health and physician placement should continue to be emphasized and that local medical societies might, when feasible, give particular recognition to medical students coming from that area. The Junior-Senior Day should be continued and expanded as seems practical.

With increasing industrialization great emphasis must continue on industrial medical practices and programs.

The Traffic Safety Committee should continue its liaison with other agencies and especially with the county medical societies and hospitals.

Each committee in its various fields should be available for conferences with other groups, for example other Commissions—the Voluntary Health Agencies, Governmental Health Agencies, or even lay groups when such groups have a valid interest or ask assistance in a problem in which we are interested.

EMMETT B. LAMB, M.D., *Chairman*
 RICHARD C. SWAN, M.D., *Vice-Chairman*
 FORREST J. BABB, M.D., *Secretary*
 RALPH O. SMITH, M.D.
 HOWARD T. HAMMEL, M.D.
 BENJAMIN A. RANCK, M.D.
 GERALD F. KEMPF, M.D.
 JOHN A. DAVIS, M.D.
 JOHN HICKAM, M.D.
 STEWART BROWN, M.D.
 JACOB C. FLEISCHER, M.D.
 E. S. RIFNER, M.D.
 WILLIAM J. GERDING, M.D.
 ROBERT J. FROST, M.D.
 ARNOLD W. BROCKMOLE, M.D.

Voluntary Health Agencies

The Commission on Voluntary Health Agencies for 1960-61 was composed of the following:

- (1st Distr.) Virgil McCarty, 113 S. Main St., Princeton
- (2nd Distr.) Herbert O. Chattin, 729 Main St., Vincennes
- (3rd Distr.) Kenneth H. Brown, 410 E. Spring St., New Albany
- (4th Distr.) Robert M. Reid, 2225 Central Ave., Columbus
- (5th Distr.) Anne S. Nichols, 707 E. Seminary, Greencastle
- (6th Distr.) Lucian A. Arata, 327 W. Broadway, Shelbyville
- (7th Distr.) Norman R. Booher, 447 E. 38th St., Indianapolis
- (8th Distr.) James L. Doenges, 1931 Brown St., Anderson
- (9th Distr.) Charles E. Rutherford, Otterbein
- (10th Distr.) Walfred A. Nelson, 559 S. Lake St., Gary
- (11th Distr.) Wendell Ayres, 303 Glass Block, Marion
- (12th Distr.) Franklin Bryan, 512 Medical Cent. Bldg., Ft. Wayne

(13th Distr.) Louis C. Bixler, 615 Sherland Bldg.,
South Bend

(at large) James Gosman, 2901 N. Meridian, Indi-
anapolis

(at large) Wendell A. Shullenberger, 3740 Central,
Indianapolis

During the past year, this commission held six meet-
ings: Oct. 5, Nov. 6, Dec. 1, Dec. 11, 1960; Jan. 29 and
May 21, 1961.

At the organizational meeting Oct. 5, 1960, Dr. Anne
S. Nichols of Greencastle was elected secretary, Dr.
Herbert O. Chaitin of Vincennes, vice chairman and
Dr. Norman R. Booher, Indianapolis, chairman. The
budget for this commission for the year was allowed
in the amount of \$800. At the beginning the commis-
sion planned for a continuation of the liaison with the
voluntary health agencies operating on a state level
that was started in the previous year.

By the assignment of members of the commission
to definite voluntary health organizations, we planned
to bring the members of this commission into closer
contact with the voluntary health agencies; not only to
understand them better, but to give them a better under-
standing of the aims and purposes of the Indiana State
Medical Association. At the beginning, each member
of the commission was given at least two assignments
to voluntary health agencies and was asked to keep in
touch with the officials and governing boards of those
agencies. In most instances, the member assigned to a
definite agency was asked to sit in with the Board of
Directors and otherwise meet with the agencies at the
time they conducted business.

A great deal of the source material for the use of
this commission during the past year has come from
the book published by the American Medical Associa-
tion entitled, "Handbook for Medical Societies and
Individual Physicians on National Voluntary Health
Agencies." The distribution of this booklet was made
throughout the state to county secretaries and the com-
mission feels that it would be very wise if every mem-
ber of the Indiana State Medical Association had the
opportunity and took the time to become familiar with
the contents of this book which sets forth many facts
about the principal voluntary health agencies, at least
on a national level.

Several times during the year the commission was
called on to work in cooperation with other commis-
sions, especially the Commission on Public Health;
and in each instance, the commissions involved came to
amiable and complete agreement on the problems being
considered. Several matters were presented to the
Council as joint decisions of this commission and the
Commission on Public Health. The most consequen-
tial of these reports concerned the Arden House Re-
port on Tuberculosis.

On Dec. 11, 1960, the commission met with repre-
sentatives of a large number of the voluntary health
agencies of the state of Indiana. These exact agencies
are listed in the minutes of the commission. At this
meeting, the President of the Indiana State Medical
Association, Dr. Guy A. Owsley, attended, as did the
President-Elect, Dr. Harry R. Stimson. The policy of

this commission was set forth at this time in a reso-
lution, which recognized the worthwhile value of the
voluntary health agencies and urged that the members
of the Indiana State Medical Association become affili-
ated and active on various levels in these organizations
in order to give them proper medical leadership and
guidance. A discussion of the mutual obligations be-
tween medical societies and voluntary health agencies
was undertaken at this meeting and a set of policies
of these mutual obligations are listed in the minutes
of the commission. Based on this set of policies, the
later work of the commission was accomplished.

At this meeting, it was decided to seek further in-
formation about the possibility of legislative action to
properly control voluntary health agencies in this state.
It was felt that more information was needed and that
some scientific control should be exercised over these
agencies having to do with health matters and that the
doctors of the state, represented by the State Medical
Association, should seek some matter of control which
is not available at the present time.

A proposed bill for an act to define and regulate
voluntary health agencies and providing for the licens-
ing thereof, was presented to the commission at the
Dec. 11 meeting. This bill was in turn presented to
the representatives of the voluntary health agencies
present. While the voluntary health agencies did not
take violent exception to this bill, they felt that they
could do more to accomplish the purposes this commis-
sion sought by voluntary action. On the basis of prin-
ciple, the commission agreed that if a voluntary organi-
zation of the voluntary health agencies could be set up
and made effective, that it would be preferable to legis-
lative action. Subsequent to this meeting, the proposals
of the commission were submitted to the Council of
ISMA and approved by them in the official minutes.

On Jan. 29, 1961, the commission held another meet-
ing with the representatives of the voluntary health
agencies as listed in the minutes of the commission.
At that time the commission presented to the voluntary
health agencies the list of criteria for official recogni-
tion of voluntary health agencies by the Indiana State
Medical Association together with a statement issued
by the National Fund Raising Practices. This state-
ment had been approved by the House of Delegates of
the AMA on two previous occasions. In line with the
previous discussion, the representatives of the voluntary
health agencies presented a proposed outline for the
formation of a Voluntary Health Agency Council
which would supply the Indiana State Medical Asso-
ciation with the necessary information from which we
could either approve or disapprove of the individual
agencies who become members. This outline seemed
to be a very good start, and the commission requested
that it be developed and that a complete outline of this
newly formed Council of Voluntary Health Agencies
be presented to the commission at a special meeting for
this purpose to be held in May.

On May 21, the commission met with the represen-
tatives of the voluntary health agencies. At this meet-
ing, Mr. Robert Patty submitted the completed outline
for the formation of, "The Indiana Council of Volun-
tary Health Agencies." A complete copy of this outline

is attached to this report as integral part of the report. Together with this outline, Mr. Patty submitted a list of potential membership, but this list was not complete and is the list from which the membership of the new council will be organized plus such other voluntary health agencies that are found to be operating on a state level. Also as a part of this report are presented the criteria for the voluntary health agencies by the Indiana State Medical Association which your commission has imposed upon the new Council of Voluntary Health Agencies, together with the statement issued by the National Social Welfare Assembly in regard to the fund-raising practices which the membership of this new council must agree to and abide by.

The complete outline of this new council, together with these statements of policies are included in this report because only by reading them can the accomplishment of the Commission of Voluntary Health Agencies be realized. Upon the completion of the organization and the details of the constitution and bylaws and the election of officers of the Indiana Council on Voluntary Health Agencies, an annual report form will be submitted for each of the Voluntary Health Agencies to the Commission on Voluntary Health Agencies of the Indiana State Medical Association. This commission will then in turn either approve or disapprove or further evaluate the facts concerning each of the voluntary health agencies operating at state level in this state. This information of such approval or other decision will be transmitted to all the members of the Indiana State Medical Association. All means of disseminating information available to the State Association must be used to bring this data to our membership; and if this is done, the purpose of the commission should be well served, because if a voluntary health agency is worthy of our support, it will be approved. However, if they are not worthy of the support of organized medicine, these facts will be made available to our membership and thus the public will be better served.

In reaching the point of the actual establishment of the Indiana Council of Voluntary Health Agencies, your commission feels that an unique accomplishment has been completed. Of course, the practical working of this plan lies in the future and in the diligence of the Commission of Voluntary Health Agencies of the Indiana State Medical Association. This bold venture will mean that those appointed to this commission in the future must accept a great deal of responsibility and work in order that the plan as laid forth here accomplish its purpose.

The members of the commission would like to express their sincere appreciation to Mr. James Waggener, Executive Secretary, and the members of his staff who have sat through many hours of note taking, recording, "hosting," and letter writing in order that the things outlined in this report could come into being. In submitting this report, the chairman wishes to extend his heartfelt appreciation to every member of the commission who attended an unusual number of meetings

for unusually long hours, in order to make the work of the commission as successful as reported here.

NORMAN R. BOOHER, M.D., *Chairman*

Please Note: This report includes copies of, "Indiana Council of Voluntary Health Agencies," "Potential Membership of Indiana Council of Voluntary Health Agencies," "Criteria for Official Recognition of Voluntary Health Agencies" and, "Statement issued by the National Social Welfare Assembly with Regard to Fund-Raising Practices," copies of which you have previously been sent.

INDIANA COUNCIL OF VOLUNTARY HEALTH AGENCIES

PURPOSES:

1. Coordination of efforts to protect and improve the health of the people in the State of Indiana.
2. Cooperation and effective liaison with all official and non-official health agencies and professional organizations in the coordination of health activities on a state-wide basis.
3. Provision of a medium for exchange of ideas and experiences, better inter-communication, and opportunity for professional fellowship and common counsel.
4. Clear interpretation of the role of the voluntary health organization in the American way of life.
5. Encouragement of high standards of achievement by all voluntary health agencies in Indiana, with emphasis on mutual understanding and support.
6. Assurance to the public that member agencies are providing needed programs on the basis of sound planning and management warranting continued public support.

OBJECTIVES:

1. To establish and maintain an organization of voluntary health agencies substantially functioning on a state-wide basis, which meet established qualifications for membership.
2. To develop a common language of communication understandable to each other and to the public.
3. To develop comparable methods of reporting programs and finances.
4. To build a concept of health agencies which will be readily identifiable to the public and which will win its confidence.

Procedures to reach objective #1:

To establish and maintain an organization of voluntary health agencies substantially functioning on a state-wide basis which meet established qualifications for membership.

The aim of procedures to establish this objective shall be to:

- 1) Accomplish the objective through democratic procedures which will foster the maintenance of the organization on a mutually satisfactory basis for the agencies participating in its organization.
- 2) Accomplish the stated purposes of the organization.

Suggested Procedures:

1. The informal group now cooperating to form such an organization will operate under Roberts Rules of Parliamentary Procedure or other mutually acceptable rules of procedure.
2. All qualified voluntary health agencies or organizations shall be given a written invitation to send a representative to participate in all meetings held for the purpose of establishing this organization and these agencies shall be presumed to be members in good standing, subject to standards for maintenance of the organization to be set up and agreed upon by those members actually participating in the organizational meetings.
3. Dates, times and places of meetings shall be established by common consent from alternative suggestions.
4. Prior to the formal organizational meeting, proposed membership standards shall be mailed to all members of the steering committee for review.

5. When initial membership has been completed, a meeting shall be called for the purpose of electing officers. This meeting shall be presided over by some person selected from participating agency who is not eligible for election. A nominating committee shall be named by voice vote of attending representatives of the participating agencies and this committee shall present candidates for president, president-elect and secretary-treasurer. Voting shall be by written ballot.
6. When officers have been elected, a committee shall be named by the president to draft a constitution and bylaws based on the recommendation of the Committee on Purposes, Objectives and Procedures as approved by the members in good standing.
7. All reports of all committees, including reports of the Committee on Purposes, Objectives and Procedures, the Committee on Definitions, the Committee on Reporting Methods, and any others, shall be presented to the Council for consideration. Matters under consideration shall not be presented for consideration elsewhere until approved by the Council.
8. The Council shall consider and agree on needs for and methods of financing necessary expenditures on behalf of the Council. All expenditures shall be subject to approval of the Council.
9. The Council shall consider and agree on methods of and procedures for processing reports from member agencies.
10. The Council shall set a regular meeting date and time for future meetings as may be agreed upon by the members. Changes may be made, if necessary, by mutual agreement.
11. The Council address for receipt and filing of communications, reports, membership dues, etc., shall be the office of the secretary-treasurer of the Council.
12. The secretary-treasurer shall be responsible for taking the minutes of meetings and reporting to the Council on matters of Council business.

Procedures to reach objective #2:

To develop a common language of communication understandable to each other and to the public.

Aim: To reduce misconceptions, misunderstandings and other symptoms of faulty communication which hinder attainment of the stated purposes of the organization.

Suggested Procedures:

1. The Council shall establish a Committee on Definitions, with rotating membership, to seek common definitions of common terms for consideration and adoption by the Council as being mutually understandable and acceptable to the members.
2. The Council shall establish a Committee on Communication to study ways and means of evaluating possible evidence of faulty communication and of overcoming it by such methods of procedure as may be approved by the Council after due consideration.
3. Provision shall be made both for providing and for receiving information and ideas which will improve communication.
4. Provision shall be made for finding better ways of discovering how health and public health issues fit into the private worlds of people.
 - a. There is a need, also, to learn who the various groups comprising the "public" identify as their trusted communication "gatekeepers." What are the informal channels through which they obtain new ideas? Whom do they see as the experts on problems relating to health? Where do these experts seek advice?
5. The Committee on Communication, and the Council, shall have access to outstanding reference material available in performing its responsibilities. As one step in this direction, the Committee shall be requested to compile a brief bibliography of outstanding communications reference materials.

Procedures to reach objective #3:

To develop comparable methods of reporting programs and finances.

Aim: To reduce difficulties of understanding variations in program and financial reporting procedures by setting mutually acceptable standards where possible.

Suggested Procedures:

1. The Council shall establish a Committee on Agency Reporting to review present methods of reporting among the various member organizations and to recommend such specific procedures for common reporting as will accomplish the stated aim above.

Procedures to reach objective #4:

To build a concept of health agencies which will be readily identifiable to the public and which will win its confidence.

Aim: To reach a common understanding of the basic and particular factors which might cause the public to lose confidence in voluntary health agencies and to take positive action to avoid them.

Suggested Procedures:

1. The Council shall establish a Committee on Human Relations, following the same general procedures necessary to accomplish objective #2 and broadening the scope to accomplish objective #4.
2. The committee shall evaluate the facilities available, and the coordination required, and make recommendations to the Council for positive action to attain the stated objective.

POTENTIAL MEMBERSHIP OF INDIANA COUNCIL OF VOLUNTARY HEALTH AGENCIES

Alsac, 611 Mass. Ave., Indianapolis (St. Jude Hospital Project)
—Leukemia; M. F. Tamer, Executive

American Cancer Society, Indiana Division, 215 E. New York
St., Indianapolis; William Cordell, Executive Director
Independent Cancer Society—

Clay County Cancer Society, 1220 E. National Avenue,
Brazil

Whitley County Cancer Society, Route 7, Columbia City

Fayette County Cancer Society, 531 Central Avenue, Connersville

Cancer Society of Elkhart County, 215 W. Franklin Street,
Elkhart

Allen County Cancer Society, 3138 Fairfield Avenue, Ft.
Wayne

Cancer Society of Huntington County, 320 Cherry Street,
Huntington

Little Red Door, Marion County Cancer Society, 1101 W.
Tenth St., Indianapolis

Noble County Cancer Society, Kendallville

LaPorte Cancer Society, 707 Harrison Ave., LaPorte

Cancer Society of Shelby County, Court House, Shelbyville

Boone County Cancer Society (Mrs. Opal Thompson)

Route 4, Lebanon

Grant County Cancer Society, P. O. Box 783, Marion

Cancer Society of Henry County, 1010 Church St., New
Castle

Cancer Society of St. Joseph County, 521 West Colfax St.,
South Bend

Wabash County Cancer Society, 142 Stitt Street, Wabash

Arthritis and Rheumatism Foundation, Ind. Chapter, 215 E.
New York St., Indianapolis

Association of Retarded Children, Ind. Chapter, 615 N. Alabama
St., Indpls.; Frank Scherrer, Pres., 3359 S. Pennsylvania
St., Indianapolis

City of Hope, 2202 W. Michigan St., Indianapolis (Cancer &
Leukemia) Mrs. Jack Ladin, 5324 Carrollton Ave., Indianapolis

Council for the Blind, Indiana Chapter, 321 N. Main St.,
Goshen; Russell Getz, Chairman

Evansville Epilepsy League, 11 Main St., Evansville; Mary Litty,
Executive Director

Indiana Association for Mental Health, 615 N. Alabama St.,
Indianapolis; Joe Brown, Executive Director

Indiana Chapter Paraplegic Association

Indiana District, National Hemophilia Foundation, 3445 Caroline
Ave., Indpls.; Mr. Richard Andrews, President

Indiana Health Foundation, 122 North Lafayette Blvd., South Bend, Ind.; Dr. George Plain, President
 Indiana Heart Association, Inc., 615 N. Alabama St., Indianapolis; Robert H. Patty, Executive Director
 Indiana Society for Crippled Children and Adults, 6055 N. College Ave., Indpls.; M. O. Jeglum, Executive Director
 Indiana Tuberculosis Association, 130 E. Washington St., Indianapolis; Chester D. Kelly, Executive Director
 Indianapolis Diabetes Association, Inc., 821 Hume Mansur Bldg., Indianapolis; Mrs. Charles Wm. McNeeley, Executive Secretary
 Lake County Chapter of the Arthritis and Rheumatism Foundation, Gary, Ind.; Miss Marilyn Carstens, Executive Secretary
 Multiple Sclerosis Society, Indiana Chapter, 615 N. Alabama St., Indianapolis; Mrs. Robert J. Shultz, Executive Director
 Muscular Dystrophy Association of America, 445 Illinois Bldg., Indianapolis; Mr. John T. Deifel, Executive
 Muscular Dystrophy Foundation, 615 N. Alabama St., Indianapolis; Miss Mary Alice Wilson, Executive Secretary
 Myasthenia Gravis Foundation, Inc., 1001 Fieldcrest Lane, Anderson, Ind.; Gordon France, Chairman
 The National Foundation, 966 N. Meridian St., Indianapolis; Larry Eberlein, Executive
 St. Joe County Chapter of the Arthritis and Rheumatism Foundation, South Bend; Mrs. Frances Fick, Executive Secretary
 Social Health Assn. of Indianapolis and Marion Co., 615 N. Alabama St., Indpls.; Mrs. Betty Jackson, Executive
 Society for Prevention of Blindness, Indiana Chapter, 1100 W. Michigan, Indpls.; Mrs. Marcia Butcher, Executive
 United Cerebral Palsy of Indiana, 615 N. Alabama St., Indianapolis; N. H. Keljik, Executive

CRITERIA FOR OFFICIAL RECOGNITION OF VOLUNTARY HEALTH AGENCIES

1. Must conform to fund raising practices of National Social Welfare Assembly.
2. Must request approval by the Indiana State Medical Association and agree to utilize qualified medical guidance from the Association to an adequate degree in planning and implementing medical and research activities.
3. Must clearly define its relationship (if any) with a national group in regard to its status or degree as ancillary or independent unit.
4. Must state fully its purpose and objectives as related to health services and medical care and research.
5. Must demonstrate adequately that its objectives and fund goals are realistic when related to actual needs.
6. Must show that cost of fund raising and administration is reasonable in relationship to total expenditures towards its stated objectives.
7. Must show that educational and promotional materials used are medically sound and presented in good taste.
8. Must relate its expenditures and services to needs for such services and to established medical care patterns.
9. Must justify its research expenditures by morbidity and mortality incidence and research needs.

STATEMENT ISSUED BY THE NATIONAL SOCIAL WELFARE ASSEMBLY WITH REGARD TO FUND-RAISING PRACTICES

The National Social Welfare Assembly has long been concerned regarding the subject of National Agency Financing. Consequently, several years ago it organized a committee on national agency financing to discuss those matters with which all social welfare and health agencies are concerned. Prompted by some of the investigations on fund-raising rackets in this country, precipitated by an investigation in New York City about two years ago, the National Agency Financing Committee of the National Social Welfare Assembly concerned itself directly with the development of some standards of fund-raising practices for social welfare organizations. This committee worked closely with the National Information Bureau and had on its drafting committee members of fourteen of the

large social welfare and health agencies of the country. As a result the committee established the attached Standards of Fund-Raising Practices for social welfare organizations.

Each of the agencies listed as signatories to these standards submitted said standards to their respective Boards of Directors for acceptance and implementation. Subsequently these agencies have accepted these standards.

It is important to realize that these agencies raise more than three-quarters of a billion dollars each year, which emphasizes the fact that a great majority of the contributed dollars from the American public for health and welfare purposes is raised according to acceptable standards by social welfare agencies. This is contrasted to the relatively small amount of money which it is said is fraudulently raised throughout the country. We condemn the small handful of organizations which betray the public trust through the use of such methods and which thereby tend to harm the hundreds of organizations which conduct their fund-raising programs according to accredited methods.

Following are the "Standards of Fund-Raising Practice for Social Welfare Organizations" subscribed to by the signatories:

1. *Board.* Responsible direction of this organization is in the hands of an active voluntary board, serving without compensation, holding regular meetings, and exercising effective administrative control.

2. *Program.* The agency maintains an active and necessary program. Objectives are being pursued with careful regard (a) to the welfare of the public and of the persons served by the program; (b) to efficiency of operation; and (c) to consultation and cooperation with other organizations, and particularly those in the same or related fields.

3. *Finances.* Fiscal operations of the agency are conducted in accordance with a detailed annual budget prepared and approved at the beginning of the year, with such current changes as may be authorized by the Board of Directors. At the year's close an audit is made by an independent certified public accountant or trust company, showing all income, disbursements, assets, liabilities, endowments, reserves and surplus in reasonable detail.

4. *Ethical Methods of Promotion.* Only ethical methods of fund-raising are employed by the agency or on its behalf. The publicity and promotional activities in connection with fund-raising are based on the actual program and operations of the agency. Protection is afforded against unauthorized use of agency contributors' lists.

5. *Fund-Raising Methods.* The agency does not mail unordered tickets or commercial merchandise with request for money in return. The telephone is not used for soliciting funds from the "general" public. No arrangements are entered into to raise funds on a commission basis.

6. *Fund-Raising Costs.* The agency is pledged to honest reporting of fund-raising costs, and to the development of improved standards of recording such costs. Fund-raising costs are disclosed to contributors and to the general public in the report mentioned below.

7. *Report.* The agency prepares annually a report which includes a full account of activities, names of board members and chief administrative personnel, and a complete audit report, with appropriate detail, including the cost of fund raising. Information regarding finances and program is available to the contributors and the general public.

(Signed) Robert E. Bondy, Director of the National Social Welfare Assembly on behalf of the following agencies:

American Cancer Society
 Leonard V. Griffith
 Director of Field Services
 American Hearing Society
 Herschel W. Nisonger, President
 American Heart Association
 Rome A. Betts, Executive Director
 American National Red Cross
 Albert W. Wold, National Director
 Fund Raising
 American Social Hygiene Association
 Philip R. Mather, President
 Arthritis & Rheumatism Foundation
 Gen. George Kenney, President

Big Brothers of America
 Charles G. Berwind, President
 Child Welfare League of America
 Joseph H. Reid, Executive Director
 Council of Jewish Federations and Welfare Funds
 Philip Bernstein, Executive Director
 Council on Social Work Education
 Ernest F. Witte, Executive Director
 National Tuberculosis Association
 Clarence W. Kehoe
 Director, Christmas Seal Sale
 The Salvation Army
 Col. P. L. Debevoise, Nat'l. Secretary
 United Cerebral Palsy Association
 Whitney R. Kerchner, Act. Exec. Dir.
 United Community Funds & Councils of America
 Ralph H. Blanchard, Director
 International Social Service,
 American Branch
 William T. Kirk, General Director
 Muscular Dystrophy Assn. of America
 Arthur A. Gallway
 Director of Field Organization
 National Assn. for Mental Health
 Richard P. Swigart, Exec. Dir.
 Nat'l. Federation of Settlements & Neighborhood Centers
 John McDowell, Executive Director
 National Jewish Welfare Board
 Joseph H. Cohen, Treasurer
 Nat'l. Probation & Parole Association
 Will C. Turnblad, Director
 Nat'l. Society for Crippled Children and Adults
 Dr. Dean W. Roberts, Exec. Dir.
 Nat'l. Society for Prevention of Blindness
 Franklin M. Foote, M.D., Exec. Dir.
 Nat'l. Travelers Aid Association
 Laurin Hyde, General Director
 United Seamen's Service
 Otho J. Hicks, Exec. Director
 United Service Organizations
 Justin Morrill
 YWCA of the USA
 Mrs. F. Beardsley Foster, Jr., V.P.

Medical Economics and Insurance

The organizational meeting of the commission was held in the Student Union Building, Indianapolis, Indiana on Sunday, Oct. 30, 1960. The work of the commission was divided among four sub-committees as follows:

Sub-Committee A—Prepaid Insurance for Aged (Indigent and Voluntary): Murray E. Harden, M.D., Chairman, Hubert T. Goodman, M.D., Clifford Taylor, M.D., Robert N. Bills, M.D.

Sub-Committee B—Minimum Standards for Insurance; and Cooperative Care of the Surgical Patient: Albert T. Jones, M.D., Chairman, Jack W. Hannah, M.D., John Langohr, M.D.

Sub-Committee C—Nursing Homes; and Medical Foundations: William H. Garner, Jr., M.D., Chairman, Willard T. Barnhart, M.D., William Scharbrough, M.D., Edward T. Edwards, M.D.

Sub-Committee D—Blue Cross-Blue Shield, Pathology and X-Ray Transfer: John W. Beeler, M.D., Chairman, Morris D. Wertenberger, M.D., Richard P. Good, M.D.

This commission has met five times during the year. It met jointly with the Commission on Governmental Medical Services Dec. 11, 1960 to discuss the Kerr-Mills Bill and the State Legislature's possible reaction to it.

Dr. Don Wood, Chairman of the Commission on Legislation, met with this commission on January 29, 1961, to discuss in detail the Brokenburr-Dickinson Bill (S.B. #221) being considered in the Indiana Legislature. This commission voted to endorse S.B. #221 as the preferred means of implementing the Kerr-Mills Bill in Indiana.

This Commission had as guests on May 21, 1961, Dick Kilborn, representing Blue Shield, and Mr. Peterson, President of the Indiana Health Underwriters' Association. Mr. Kilborn discussed some problems Blue Shield is facing that are of interest to this commission. Mr. Peterson gave us a brief discussion of minimum standards for health insurance.

Reports from sub-committees for the year:

Sub-Committee A

Item 1: Medical Care for Welfare Recipients. We will be governed by the Brokenburr Bill passed in the last legislature for the purpose of implementing the Kerr-Mills Bill in Indiana.

Item 2: Prepayment for over 65 age group. No plan other than the existing standard Blue Shield plan and commercial plans are offered.

Sub-Committee B

Item 1: Minimum standards for insurance. The commission feels that this is a complex subject requiring special knowledge of the various aspects of health insurance. We recommend that a joint committee selected from this commission and from such organizations as the Indiana Health Underwriters' Association and the Health Insurance Council could be helped to our commission and the insurance organizations trying to establish ethical standards for health insurance planning and marketing.

Item 2: Cooperative care of the surgical patient. This Commission feels that the new Blue Shield rider, offering coverage for cooperative care, will probably answer the need in this area satisfactorily.

Sub-Committee C

Item 1: Minimum Standards for Nursing Homes. This problem is discussed in general terms in a brochure available from the AMA. The Chairman of this Commission is to discuss the problem with Dr. Spolyar, Director, Bureau of Preventive Medicine, Indiana State Board of Health, who has offered to work with us in studying the needs in this field.

Item 2: Medical Foundations. This commission is advised by Dr. Barnhart that a medical foundation is being formed in Evansville, but is not yet in operation (as of May 21, 1961). We have no information regarding any other similar organizations in Indiana.

Sub-Committee D

Item 1: Blue Cross and Blue Shield—Pathology and X-Ray Transfer: "Several meetings were held this year, including one meeting in which the Executive Secretary of the American College of Radiology attended. There seems to be little chance of changing the mechanism of payment of hospital employed physicians in regard to the pending legislation of the King-

Anderson Bill in Washington. This committee believes that the ISMA must take a firm stand in opposing the King-Anderson Bill, since under its provisions the services of Anesthesiologists, Physiatrists, Pathologists and Radiologists would be included as hospital services by the Federal Government. In addition, the patients over age 65 would be obligated to use the hospital departments of radiology, pathology and physical therapy, which would increasingly jeopardize the private practice of these specialties outside the hospital. The picture is bleak and this sub-committee is discouraged.”*

The Commission on Medical Economics and Insurance, therefore, recommends that we should insist on the transfer of all physicians' services from Blue Cross to Blue Shield mechanism of payment. This would encourage broader out-of-hospital coverage and reduce "admissions of convenience" for insurance coverage. It would also correct the basic fault of some doctors being paid for their professional services through Blue Cross, while all other physicians' services are indemnified through Blue Shield.

LOWELL I. THOMAS, M.D., *Chairman*
JOHN LANGOHR, M.D.
EDWARD T. EDWARDS, M.D.
WILLARD T. BARNHART, M.D.
WILLIAM H. GARNER, JR., M.D.
WILLIAM D. SCHARBROUGH, M.D.
HUBERT T. GOODMAN, M.D.
MORRIS D. WERTENBERGER, M.D.
ALBERT T. JONES, M.D.
MURRAY E. HARDEN, M.D.
ROBERT N. BILLS, M.D.
RICHARD P. GOOD, M.D.
JACK W. HANNAH, M.D.
CLIFFORD C. TAYLOR, M.D.
JOHN W. BEELER, M.D.

* Extracted from minutes of the Sub-Committee on Transfer of Blue Cross-Blue Shield Payments.

Inter-Professional Relations

The Commission on Inter-Professional Relations held an organizational meeting Oct. 5, 1960. After election of officers, a discussion was held of the Final Report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services to the 1960 House of Delegates of the American Medical Association. A copy of this report was sent to each member of the commission.

One other meeting was held Jan. 12, 1961, at the Student Union Building, Indiana University Medical Center. The report referred to above was discussed. The committee which prepared the report from the American Medical Association was appointed in 1957 to consider how physician leadership can best be activated in relationships with professional and technical personnel closely related to medicine, and to study the matter of liaison at the professional and technical level leading to the above objective. The need for this study has resulted from the rapid expansion of the scope of scientific knowledge in the recent past and present which has created a constantly growing demand for a greater

diversity of skills and for ancillary help to the physician in medical education and in caring for health. Two examples of this growing problem are the fact that in 1958 there were two and one-half times as many Ph.D's as M.D's engaged in teaching and research in the basic medical sciences and that there are already some eight individuals in allied health activities for each physician engaged in patient care. This has created new sociologic, economic, educational and legal problems.

The Law Division of the American Medical Association explored the extent of the problem and discovered that there were 50 areas and that there were 44 distinct classifications of allied medical personnel who were actively engaged in the care of the patient. These were as follows:

1. Anatomists
2. Audiologists
3. Basal metabolic technicians
4. Bioanalysts
5. Biochemists
6. Biophysicists
7. Biostatisticians
8. Chiropodists
9. Clinical Chemists
10. Corrective therapists
11. Cyto-technologists
12. Dietitians
13. Electrocardiographic technicians
14. Electroencephalographic technicians
15. Electrolgists
16. Epidemiologists
17. Histologic technicians
18. Hospital administrators
19. Industrial hygienists
20. Inhalation therapy technicians (Oxygen therapy technicians)
21. Lay psychoanalysts
22. Masseurs and mechano-therapists
23. Medical illustrators
24. Medical record librarians (Medical record technicians)
25. Medical social workers
26. Medical technologists
27. Microbiologists
 - Bacteriologists
 - Immuno-serologists
 - Mycologists
 - Parasitologists
 - Virologists
28. Midwives
29. Music therapists
30. Nutritionists
31. Occupational therapists
32. Opticians
33. Optometrists
34. Orthoptic technicians
35. Pharmacists
36. Pharmacologists
37. Physical therapists

38. Physiologists
39. Prosthetists
40. Psychiatric social workers
41. Psychologists
 - Clinical psychologists
 - Counseling and guidance psychologists
42. Public health educators
43. Radiation therapy technicians
44. Recreational therapists

In many of these fields, educational standards, licensing laws and the organization of professional groups has occurred without the participation or guidance of the medical profession which must ultimately direct these people in the care of the patient and bear the responsibility for their activities.

These facts have been used in the study made by The Brookings Institution of Washington, D. C., under the auspices of the Ford Foundation to arrive at the conclusion that "Medicine has ceased to be a profession and is now an industry." It is no longer possible for a single doctor to deliver a total medical product. The authors of that study go ahead to the conclusion that only federal regulations can prevent chaos in the medical field.

Inquiry into the situation in Indiana at the present time resulted in the conclusion that there are at present no pressing problems between the Indiana State Medical Association and the organizations of present ancillary health services.

Occasionally there are requests for cooperation in projects, or meetings, which are handled by the Council. Any thorough study, or activity, would require secretarial assistance and a substantial expenditure.

Dr. Joseph B. Davis submitted a report as Chairman of the Joint Commission for the Improvement of Patient Care in Indiana. Five members of the Commission served as representatives of the Indiana State Medical Association on this committee. The committee has been broadened to include representation from the Indiana Association of Licensed Nursing Homes and the Indiana Dental Association. Two years ago membership was extended to a representative of the A.F.L.-C.I.O. Such a representative was appointed but has attended no meetings in the past two years. The committee has suffered by the absence of Dr. Martha O'Malley and Dr. Rozelle who have been critically ill. Dr. Davis expresses appreciation for the diligent attendance of all the other physicians who served as representatives at the meetings. The committee is to take the initiative in planning an institute during the coming winter covering patient care. This will be initiated by contacting Dr. Scamahorn, Chairman of the Special Activities Commission of the Indiana State Medical Association. It is anticipated that the Indiana State Hospital Association and the State Board of Health would be interested in cooperating in the creation of such an institute.

Dr. Davis, who has served brilliantly as chairman of the committee for several years, again expresses the hope that one of the other physicians might possibly be

prevailed upon to take this responsibility as of the first of the year.

ROBERT H. RANG, M.D., *Chairman*
 ROBERT D. HOWELL, M.D., *Vice-Chairman*
 JOHN W. RIPLEY, M.D., *Secretary*
 JOSEPH D. McDONALD, M.D.
 W. T. PAYNTER, M.D.
 PAUL HUMPHREY, M.D.
 FRANK H. GREEN, M.D.
 FLOYD A. BOYER, M.D.
 R. D. WILLIAMS, M.D.
 KENNETH O. NEUMANN, M.D.
 M. B. GEVIRTZ, M.D.
 JOSEPH B. DAVIS, M.D.
 JACK L. EISAMAN, M.D.
 F. R. N. CARTER, M.D.
 NEAL BAXTER, M.D.

Medical Education and Licensure

The original meeting of the commission was held Oct. 3, 1960, in conjunction with the meeting of the Indiana State Medical Association. At this time the undersigned was elected chairman, Dr. Harry Klepinger, vice-chairman and Dr. Kenneth Kohlstaedt, secretary.

The next meeting of the commission was held on Nov. 20, 1960, at the Student Union Building, Indiana University Medical Center. During this meeting the following were appointed to sub-committees:

Sub-Committee on Medical Education: Ralph C. Eades, Chairman, Dallas Fickas, M.D., Robert W. Harris, M.D., Jack E. Shields, M.D., Irwin S. Hostetter, M.D., Francis E. Carrel, M.D., Elton R. Clarke, M.D.

Sub-Committee on Licensure: William N. Wishard, Jr., M.D., Chairman, William C. Reed, M.D., Basil M. Merrell, M.D., Norman F. Richard, M.D., G. O. Larson, M.D.

Dr. Harry Klepinger was appointed chairman of the Intern Day Program, and at a later date Dr. Klepinger and Dr. John Mahoney met with the commission and prepared a program for Intern Day on April 19, 1961. The program was as follows:

PROGRAM

The Development of an Educational Program in a
 Community Hospital
 April 19, 1961
 Student Union Building

- | | | |
|------------|--|----------------------|
| 9:45 a.m. | Registration | |
| 10:00 a.m. | Welcome | |
| | | Dean John Van Nuys |
| | | Introductory Remarks |
| | | Guy Owsley, M.D. |
| 10:15 a.m. | "The Student's Viewpoint on the Weakness in the Education Program in Hospitals" | |
| | | Mr. Robert Hollowell |
| | Discussion | |
| 11:15 a.m. | "What Particular Advantage does the Community Hospital Offer on Educational Program" | |
| | | Jack Hall, M.D. |
| | Discussion | |

- 11:45 a.m. "Planning for a State Wide Study of the Total Hospital Educational Program"
Kenneth Kohlstaedt, M.D.
Discussion
- 12:30 p.m. Lunch
Medical Science Building, Room 102
- 2:00 p.m. Sophomores and Juniors will be available for counsel regarding externships and internships.

This program was well received and the Commission on Education would recommend that a program of national stature should be prepared for Intern Day for 1962. We submit herewith the outline of a program which might be done and request authority from the House of Delegates to carry out such program.

TENTATIVE PROGRAM SECOND ANNUAL CONFERENCE ON GRADUATE MEDICAL EDUCATION

"Educational Problems in the Intern and Residency Program in the Community Hospital"

- Introductory Remarks
- Explanation of the Organization of the Conference
- Present and Future Status of the Demand and Supply of Interns and Residents
- Educational Aspects of the Intern and Residency Programs
- Coffee Break
- Administrative Aspects of the Intern and Residency Program
- Educational Responsibilities of the Community Hospital
- Lunch
- Workshops

1. The Importance of the Administrative Organization of the Hospital to the Intern-Residency Program
2. The Impact of Medical Insurance on Intern-Residency Training Programs
3. The Place of Research in the Intern-Residency Training Program
4. The Role of the Director of Medical Education in the Community Hospital
5. Education and Training Problems in the Dental Specialties
6. Approaches to the Teaching of Basic Medical Sciences in the Community Hospital
7. Method of Organizing the Intern-Residency Training Program in a Community Hospital with Minimal or Inadequate Numbers of Interns and Residents.
8. Responsibility of the Community Hospital in the Training of Foreign Interns and Residents
9. Responsibility of the Hospital to the Community
10. Ways of Meeting the Cost of a Program in Graduate Medical Education in the Hospital

- Refreshments and Dinner
- Talk on the legal responsibilities of the physician and the hospital

(Second Day)

- Workshop Reports
- Lunch
- Workshop Reports
- Termination of Conference

In October, 1960, the House of Delegates of the Indiana State Medical Association approved an award of \$500 for the writing of a thesis concerning health education. Dr. Ralph Eades served as chairman of the sub-committee dealing with this project and serving with Dr. Eades on the committee were Dr. Norman Richard, Dr. Robert Yoho and Dr. Keogh Rash. This committee reported to the commission concerning rules and regulations for thesis awards. The commission fully endorsed these rules and regulations and adopted them.

The commission met with Dr. Andrew Offutt, State Board of Health, and worked out an agreement whereby each county medical society will receive a copy of the State Board of Health's inspection report of each nursing home within the county medical society's area. Secondly, Dr. Offutt reported that the State Board of Health will submit to each county medical society its information concerning status of immunizations within the county so that each county medical society may establish their own program.

The commission recommends that each county medical society be made cognizant of these advances in communication and as a matter of information, points out the complete cooperation of the State Board of Health with the Commission on Education.

In consideration of paragraphs 3, 4, and 5, of the Reference Committee Report on Medical Education, the commission, at the request of the Executive Committee, deferred action until the meeting of the House of Delegates of the American Medical Association in New York, 1961. It should be pointed out that the commission had recommended that should no further change be made by the House of Delegates of the AMA the Indiana State Medical Association must consider this problem because of existing situations in our state. This problem has now been resolved and a copy of the official attitude of the AMA is attached to this report.

In consideration of paragraph 6 of the Reference Committee Report of the Washington State Medical Society project on discipline, it should be reported that the chairman of the commission is working closely with the chairman from the Grievance Committee of Indiana and will meet at least on one occasion prior to the State Medical Association meeting.

Resolution No. 1, introduced by the Lawrence County Medical Society. SUBJECT: Recommendation in Regard to Specialization, as referred to the Commission on Education was discussed. It was the opinion of the commission that although a problem exists in securing an adequate number of family physicians, Resolution No. 1 is not practical and would not alleviate the problem. Therefore, the commission recommended to the Council that this resolution be tabled.

Dr. Ralph Eades, Chairman of the Sub-Committee on Medical Education, was designated by the commission to attend the Eighth National Conference on Physicians and Schools which was held in Chicago on March 9, 10, and 11, 1961. His report will be submitted as supplemental.

The commission considered a communication from the Executive Committee concerning the establishment of a United Student Aid Fund to make loans available

to Indiana University medical students. While the commission was in agreement that this is an excellent program they are concerned with the fact that should the State Medical Association contribute money to this fund, a medical student would have no awareness of this, for the loan is actually secured from his local bank. The commission felt that the consideration of this item should be deferred until a later date because they felt they should request the opinion and advice of the Student Loan Committee prior to making a decision.

The commission considered the supplementary report A of the Council on Medical Education and Hospitals and recommended that the chairman of the commission, as a delegate to the American Medical Association, support same. (This report was accepted as presented by the House of Delegates of the AMA on November 30, 1960.)

The commission spent a great deal of time and effort considering the recruitment of young people as pre-medical and medical students. The commission feels that there is a necessity for an imaginative program to entice young people into medical fields. There is evidence that several successful programs are now being followed, such as in Lafayette, New Albany and Columbus, Indiana. However, it is the feeling of the commission that a state-wide program should be planned and endorsed by the Council and the House of Delegates to stimulate young people for recruitment.

The commission considered the subject of the Indiana Science Fair and the contribution by the ISMA to same. The commission recommended to the Council that the State Medical Association should participate in an amount not to exceed \$3,000. This motion was presented to the Council.

By custom, the Chairman of the Commission on Education was designated to attend the Congress on Medical Education and Licensure which was held at the Palmer House in Chicago, Feb. 4, 5, 6, and 7, 1961. The report of the chairman was printed in the *Indiana State Medical Journal* in June, 1961.

The commission received during the year the report of Dr. Elton Clarke concerning inspection of textbooks and the commission accepted this with sincere thanks to Dr. Clarke for his fine work.

The activities for the Sub-Committee on Medical Education were by far the most outstanding of the commission. Because of this, the Chairman of the Commission wishes the sub-committee chairman to submit a supplemental report which will be presented to the House of Delegates in October, 1961.

FRANCIS L. LAND, M.D., *Chairman*
HARRY E. KLEPINGER, M.D.
KENNETH G. KOHLSTAEDT, M.D.
DALLAS FICKAS, M.D.
WILLIAM C. REED, M.D.
ROBERT W. HARRIS, M.D.
JACK E. SHIELDS, M.D.
BASIL M. MERRELL, M.D.
NORMAN F. RICHARD, M.D.
WILLIAM N. WISHARD, JR., M.D.

IRWIN S. HOSTETTER, M.D.
FRANCIS E. CARREL, M.D.
RALPH C. EADES, M.D.
ELTON R. CLARKE, M.D.
G. O. LARSON, M.D.

(Excerpts from the Actions of the A.M.A. House of Delegates)

OSTEOPATHY

The Judicial Council presented a four-page report concerning this question and ended their report with this recommendation:

(1). It shall not be considered in itself unethical for members of the American Medical Association to associate professionally and on a voluntary basis with doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine in order that patients may have the full measure of the benefits of the objects of this Association as stated in Article II of its Constitution: ". . . to promote the science and art of medicine and the betterment of public health."

(2). It is the prerogative and obligation of each constituent medical association to implement this policy on a state or local basis.

The Reference Committee held hearings which were well attended and the following constitutes the report as adopted by the House:

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of AMA policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Herefore, this policy has been applied collectively at national level. The test now should be: Does the indi-

vidual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

ISMA Representative Reports on
ANNUAL CONGRESS OF MEDICAL
EDUCATION AND LICENSURE

President, Indiana State Medical Association
Chairman of Executive Committee, I.S.M.A.
1021 Hume Mansur Building
Indianapolis, Indiana

Gentlemen:

In accordance with instructions received from the Executive Committee the undersigned, as the chairman of the Commission on Education, attended the Annual Congress of Medical Education and Licensure, Feb. 4-7, 1961, at the Palmer House in Chicago.

From 12:30 until 6:00 p.m. on Saturday, February 4, a special meeting was held by the AMA Council on Medical Education with representatives from Chicago area state medical societies and representatives from medical schools within the area. The purpose of this session was to determine what the Council on Medical Education might do to improve their relationships with individual state medical societies and with their Commissions on Education. Each sub-chairman of the Council explained his job with the Council.

Discussion was free from the floor and it was pointed out to the Council that there appears to be no responsibility of the states in relationship to the Council and, therefore, no great amount of cooperation. A suggestion was made that possibly the Council should consider the routing of requests for information from local medical societies to the State Commission on Education and then after being acted upon by the state, this information to be forwarded on to the Council. There was also a suggestion that a recommended guide for the setting up of State Education Commissions be produced. A copy of a publication entitled "Guides to State Committees on Education," published by the American Academy of General Practice, and part of it written by the undersigned, will be used as a beginning guide. Other topics discussed concerned internships, residencies and particularly stipends.

All in all this initial meeting pointed out that the Council on Medical Education realizes that a great deal of its difficulties and problems exist because of poor communications with state medical organizations, and at least it is a beginning of a program to improve these communications. It would appear to me that possibly a letter from our state president to the chairman of the Council, Dr. McKittrick, might further encourage the Council to continue its program as it is now started.

The Sunday morning program was devoted entirely to papers concerning the future of family practice. It

was pointed out in these papers that the entire nation, including the patients, all segments of organized medicine and the government are deeply concerned about the shortage of family doctors. How much of a shortage there really is is shown by the statistics of the graduating class of 1950. Of this class only 15% are in general practice. The papers were interesting but offered no real solutions to the problem.

Also on Sunday various subjects were discussed. The primary question was "Is there danger of losing an appropriate balance between the basic and clinical sciences in medical school?" A new concept in this meeting was developed and that was of conducting two simultaneous debates. These debates were most interesting and concerned pertinent subjects.

Monday morning was a general session devoted mainly to the relationship of education to hospitals, while in the afternoon the important subject of "Medical care and education in hospitals without interns or residents" was covered. The two simultaneous debates were held again on Monday afternoon.

This representative also attended a session of the Federation of State Medical Boards of the United States concerned with discipline in the medical profession. Since the Commission on Education and the Grievance Committee of the I.S.M.A. are jointly discussing the Washington Plan, it was of interest to the undersigned that most states do not consider the Washington Plan as a good solution for disciplinary problems. This idea was obtained in private conversations with members representing other states.

Sincerely yours,

FRANCIS L. LAND, M.D., *Chairman*
Commission on Education

Special Activities

The Commission on Special Activities has not been too active in the past year. Its area of activities has touched; (1) chronic illness care in Indiana hospitals; (2) American Medical Education Foundation and Indiana University Foundation Cooperation; (3) Medical Ethics; (4) Blood Bank Reciprocity; (5) Indiana Sesquicentennial; and (6) Veterans' Day Program.

Early talks were made with Dr. O'Malley and her group at the Indiana State Board of Health regarding "Rehabilitation and Chronic Disease Care in Indiana Hospitals." Her group (eight in number) later appeared before our full commission and gave an excellent briefing as to the present status of care and rehabilitation of the chronically ill in Indiana hospitals. The commission would like every physician to become more aware and interested in this large problem. Roughly 33⅓% of all admissions in Indiana hospitals are chronically ill patients. An educational program should and must be forthcoming as more funds from public and private sources are available for and demanding increased chronic disease care.

Additional and continued talks were made with Indiana University Foundation regarding a joint appeal with the American Medical Education Foundation to the Indiana University School of Medicine Alumni. This appeal failed to materialize in 1960, probably due

to change in A.M.E.F. directorship. Mr. Jay Oliver, acting director of A.M.E.F., has advised us he will contact Mr. William Armstrong of the Indiana University Foundation regarding this matter. Assessment of funds for A.M.E.F. continues; also the Woman's Auxiliary is doing its usual magnificent job for A.M.E.F.

The old business completed this year was the advising of the Indiana Sesquicentennial Commission that our association would cooperate to its fullest capacity in preparation of any planned celebration. Also the problem of blood bank reciprocity has been assumed and partly solved by the group called "Joint Blood Council, Inc." of 1832 M Street, N. W., Washington, D. C. This problem has been a knotty one.

Medical ethics has been a new problem created by a letter from the 1960 House of Delegates, stating that our Commission shall evolve, "an improvement and stimulation of interest and re-education in medical ethics." Much discussion, questioning and study failed to clearly identify the problem and/or its solution. Dean Van Nuys wrote us explaining the educational program followed in our State Medical School and advised that our Association had not failed to cooperate. *The Journal* will continue its printing of the AMA ethical code. This problem is to be further studied.

Lastly, the commission agreed to cooperate with the Eleventh District American Legion Veterans' Day Committee for a November 11, 1961 program. Details are still lacking as to our participation.

The commission wishes to thank the State Medical Association office staff for their continued help during the past year.

MALCOLM O. SCAMAHORN, M.D., *Chairman*
GUY B. INGWELL, M.D., *Vice-Chairman*
ELI GOODMAN, M.D., *Secretary*
JOSEPH E. COLEMAN, M.D.
C. PHILIP FOX, M.D.
GEORGE A. MAY, M.D.
NORMAN M. SILVERMAN, M.D.
H. N. SMITH, M.D.
JACK M. WALKER, M.D.
ROBERT H. WISEHEART, M.D.
ARTHUR J. KUHN, M.D.
EARL W. BAILEY, M.D.
DAVID C. GASTINEAU, M.D.
MERLE E. WHITLOCK, M.D.
RALPH M. STEFFY, M.D.

Aging

The organizational meeting of the commission was held in the Student Union Building, Indiana University Medical Center, Indianapolis, March 26, 1961.

The following officers were elected: chairman—Nathan Salon, M.D., Fort Wayne; co-chairman—M. C. Topping, M.D., Terre Haute; secretary—Frank M. Hall, M.D., Indianapolis.

The goal of the commission is to help fix the attention of the Aged-Aging on their strengths rather than their weaknesses, as well as to inform the public

of the dangers of compulsory health insurance for the aged under the Social Security System, and to answer false propaganda about the aging-aged with facts.

Four essential work areas were agreed upon by the commission for the preservation of the health of the elderly person, as follows:

- (1) Adequate medical care programs.
- (2) Voluntary medical care insurance.
- (3) Periodic health appraisals.
- (4) Geriatric rehabilitation services.

The commission has met three times during the year, and had its final meeting July 9, 1961. A scientific exhibit for the state convention in October concerning the problems of the aging-aged will be assembled.

To present this commission's recommendations to the House of Delegates, four resolutions are offered on the subjects, listed on the following pages:

- (1) Independent Living.
- (2) Standard Health and Medical Procedures for County Homes.
- (3) County Medical Society Liaison with Local Group or Groups.
- (4) Geriatric Rehabilitation Services.

The commission, as a whole, endorses these resolutions to be introduced; they are numbered Resolution No. 1; No. 2; No. 3; and No. 4, respectively.

NATHAN L. SALON, M.D., *Chairman*
M. C. TOPPING, M.D., *Vice-Chairman*
FRANK M. HALL, M.D., *Secretary*
GEORGE M. YOUNG, M.D.
NICHOLAS C. JOHNS, M.D.
ANDREW C. OFFUTT, M.D.
L. JOHN VOGEL, M.D.
W. U. KENNEDY, M.D.
VANCE J. CHATTIN, M.D.
DON LAFOLLETTE, M.D.
HARRY R. BAXTER, M.D.
WARREN ANDREWS, M.D.
F. S. CROCKETT, M.D.
LLOYD L. HILL, M.D.
RALPH R. PLOUGHE, M.D.

The following resolution is part of the annual report of the Commission on Aging.

Subject: INDEPENDENT LIVING

WHEREAS, in a democracy, it is conceived that an individual should live in dignity and by his own initiative and effort maintain as complete a state of independence as possible throughout his lifetime; and

WHEREAS, events and situations occur to an individual at different times during his life which if not corrected or relieved result in dependency; and

WHEREAS, a person's independence may be more nearly assured when only services which are absolutely necessary to restore him to self-sufficiency are made available; and

WHEREAS, the provision of service and assistance when not absolutely necessary promotes and encourages a continuing and increasing dependency complex; therefore be it

RESOLVED, that the Indiana State Board of Health, along with the State Medical Association and other appropriate official and voluntary agencies, be encouraged to study the causes that lead to the institutionalization of the aged, physically and mentally handicapped and the chronically ill, and to explore ways by which such individuals may be enabled to maintain their independent living status for the longest possible period of time, be it further

RESOLVED, that the State Board of Health and the previously mentioned organizations and groups, upon the basis of their findings, recommend a plan for effecting a program of independent living for the State of Indiana.

The following resolution is part of the annual report of the Commission on Aging.

Subject: STANDARD HEALTH AND MEDICAL PROCEDURES FOR COUNTY HOMES

WHEREAS, a recent survey of county homes conducted by the State Board of Health and the Governor's Commission on Aging demonstrates that many of these homes do not require a medical examination on admission; and

WHEREAS, many of these same homes do not provide for periodic medical examinations of their residents and have no well-established policies on medical procedure; therefore be it

RESOLVED, that the State Board of Health study these problems for the purpose of developing a medical examination form to be used by county homes with all admissions and; be it further

RESOLVED, that the State Board of Health with the assistance of other appropriate groups, develop and recommend standard health and medical procedures to those responsible for the administration of county homes and; be it further

RESOLVED, that the State Board of Health should work closely with County Commissioners in implementing the above recommended action.

The following resolution is part of the annual report of the Commission on Aging.

Subject: COUNTY MEDICAL SOCIETY LIAISON WITH LOCAL GROUP OR GROUPS

WHEREAS, there is a continued increase of aged and aging in the population; and

WHEREAS, more and more individuals and groups are developing concern for the medical problems faced by the senior citizens; and

WHEREAS, good health or the absence of good health and the availability of medical care are important considerations in relation to any program concerned with the aging; and

WHEREAS, there is not a single county in the state that does not have within its confines nursing homes and/or county homes, and organized programs concerned with aging; therefore be it

RESOLVED, that each county medical society establish a committee or designate one of its members to serve as liaison with these institutions or groups in order that practical and acceptable health and medical care practices may be implemented.

The following resolution is part of the annual report of the Commission on Aging.

Subject: GERIATRIC REHABILITATION SERVICES

WHEREAS, it is generally agreed that many of the residents of county homes and nursing homes can benefit materially from rehabilitation services; and

WHEREAS, studies and observation indicates that rehabilitation services are practically non-existent in these institutions; and

WHEREAS, it is generally believed that best results will be achieved when rehabilitation services are administered by personnel of the institutions who are caring for the residents; therefore, be it

RESOLVED, that the State Board of Health develop a plan and a procedure by which a continuous program of training in the elementary principles of rehabilitation can be provided for the personnel of county homes and nursing homes; be it further

RESOLVED, that in the event resolutions, "Independent Living," "Standard Health and Medical Procedures for County Homes," "County Medical Society Liaison with Local Group or Groups" and, "Geriatric Rehabilitation Services" are approved, active support be given to the efforts of the State Board of Health in securing the necessary budget to carry out these activities.

Resolution No. 1

Introduced by: MADISON COUNTY MEDICAL SOCIETY

Subject: RESOLUTION REJECTING THE AMBULATORY CLINIC PLAN TREATMENT FOR NARCOTIC ADDICTION

WHEREAS, the American Medical Association and the American Bar Association have had committees studying the problem of narcotic drug addiction, and

WHEREAS, the only adequate and successful treatment of narcotic addiction necessitates constant control in a secure institution affording a drug-free environment, and

WHEREAS, experience has shown that treatment of narcotic addiction by means of various types of ambulatory clinic plans has been universally unsuccessful, impractical and scientifically unsound, and

WHEREAS, in all attempts of treatment of narcotic addiction by ambulatory methods, addiction has in fact increased,

THEREFORE BE IT RESOLVED, that the Madison County Medical Society go on record opposing the ambulatory clinic plan for the treatment of narcotic addiction, and

BE IT FURTHER RESOLVED, that the Delegates of the Madison County Medical Society present this resolution to the House of Delegates of the Indiana State Medical Association for their consideration and approval, and

BE IT FURTHER RESOLVED, that the Indiana State Medical Association Delegates to the American Medical Association be instructed to oppose the development of any such ambulatory treatment plans, and that they be instructed to recommend and support measures designed to require the compulsory civil commitment of drug addicts for treatment in drug-free institutions, (2) to advance methods and measures towards rehabilitation of the addict, and (3) to establish methods for the dissemination of factual information on narcotic addiction to the members of the medical profession.

Resolution No. 2

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: REFUND OF DUES OF DECEASED MEMBERS

WHEREAS, it is now the rigid policy of the Indiana State Medical Association not to refund dues to the widows of deceased members who died during the current (dues-paying) year, and

WHEREAS, in specific instances in which widows have requested such refunds they have been refused by the Indiana State Medical Association but have been refunded dues by component county societies; and

WHEREAS, the total amount of money that would in any calendar year be refunded would represent a

very small fraction of the total dues collected by the Indiana State Medical Association; and

WHEREAS, the refunding of dues at such time of sadness would undoubtedly be looked upon as an expression of great kindness and sympathetic understanding;

THEREFORE, BE IT RESOLVED, that the St. Joseph County Medical Society recommend that the Indiana State Medical Association refund dues paid in the current year by members to the estates of those physicians who die in the calendar year in which dues are paid, and

BE IT FURTHER RESOLVED, that the delegates to the Indiana State Medical Convention from St. Joseph County present this resolution to the entire House of Delegates for a vote at the next regularly scheduled meeting in October, 1961.

Resolution No. 3

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: MANDATORY ASSESSMENT AGAINST NEW MEMBERS

WHEREAS, The ruling of the House of Delegates of the Indiana State Medical Association in regular session in October, 1960, made mandatory a \$50.00 pledge to be paid either as a donation or as a forced loan; and

WHEREAS, upon protest by numerous counties the legal advisors to the Indiana State Medical Association proclaimed that the aforementioned ruling was unenforceable; and

WHEREAS, the ruling was never actually rescinded but remains in the record; and

WHEREAS, the Council, in session April 9, 1961, rules that all new physicians joining the Society after the above-mentioned date would be expected to assist the Building Fund by such forced donation or loan; and

WHEREAS, this taxation on doctors as yet unborn, is in essence contrary to the basic political philosophy of the Indiana State Medical Association and the American Medical Association; and

WHEREAS, the mandatory assessment now made against new members but not against present members therefore becomes discriminatory legislation in a democratic organization; and

WHEREAS, the doctors as yet unborn have no legal recourse; therefore

BE IT RESOLVED, that the St. Joseph County Medical Society recommend to the Indiana State Medical Association that present members and future members will not be forced to contribute to the Indiana State Medical Association Building Fund.

BE IT FURTHER RESOLVED, in addition, that no special assessment, contribution, donation, loan or initiation fee will be levied against new members.

BE IT FURTHER RESOLVED, that the original legislation demanding this levy be rescinded to make it read "voluntary contribution."

BE IT FURTHER RESOLVED, that the Delegates to the Indiana State Medical Convention from St. Joseph County present this resolution to the entire House of Delegates for a vote at the next regularly scheduled meeting in October, 1961.

Resolution No. 4

Introduced by: GRANT COUNTY MEDICAL SOCIETY

Subject: STUDY OF PROFESSIONAL INCORPORATION LEGISLATION AND LAWS

WHEREAS, the 1961 Indiana General Assembly considered legislation which would have authorized the members of the medical, legal and other professions to conduct the practice of their profession in the form of corporations; and

WHEREAS, the proposed legislation would have permitted those electing to incorporate, whether engaged in sole or group practice of medicine, to avail themselves of certain federal tax benefits, primarily the delayed taxation of retirement funds, now denied those prohibited by the laws of their state from incorporating; and

WHEREAS, numerous other states have considered similar legislation and certain of these have enacted laws permitting professional incorporation;

NOW THEREFORE BE IT RESOLVED BY THE GRANT COUNTY MEDICAL SOCIETY, AS FOLLOWS:

That the Grant County Medical Society recommend to the House of Delegates of the Indiana State Medical Association that a study be made of Professional Incorporation legislation as proposed in the various states and especially the laws of the states which have enacted such legislation in order that the advantages and disadvantages to the medical profession might be determined and the effect of such legislation fully explained to the members of the Indiana Medical Association; and

BE IT FURTHER RESOLVED, that should the study of professional incorporation laws result in a determination that the same are beneficial to the medical profession, a suggested law be prepared and the Indiana State Medical Association endorse its enactment by the 1963 Indiana General Assembly; and

BE IT FURTHER RESOLVED, that professional incorporation legislation, proposed or sponsored by the Indiana Medical Association, be of such nature that the benefits shall accrue and be equally available to the sole practitioner and those engaged in group practice; and

BE IT FURTHER RESOLVED, that a copy of this resolution be presented to the House of Delegates of the Indiana Medical Association.

Resolution No. 5

Introduced by: MONTGOMERY COUNTY MEDICAL SOCIETY

Subject: RESOLUTION TO CHANGE THE PROCEDURE OF EXAMINATION OF APPLICATION FOR DISABILITY UNDER SOCIAL SECURITY

WHEREAS, an applicant for Social Security, because of disability is now sent to his personal physician at the expense of applicant, and

WHEREAS, the attending physician has to complete a long examination form which is sent to the district office of Social Security, and

WHEREAS, the Social Security office then orders many applicants to certain physicians in Lafayette, Indiana, to repeat the examination, this time at the expense of Social Security and at great inconvenience to the applicant,

NOW THEREFORE, BE IT RESOLVED, that the Social Security be advised that a short statement by attending physician should be sufficient, and

FURTHER, it is suggested that where possible, final examination of applicant be done in his own community.

Resolution No. 6

Introduced by: CLAY COUNTY MEDICAL SOCIETY

Subject: PHYSICIANS ON HOSPITAL BOARDS

We propose that the present law be amended so that physicians would be eligible for election to the board of trustees of the County Hospitals in Indiana

Fireside Conferences

CARDIO-RESPIRATORY DISEASES

Tuesday, October 24th, 8:00 P.M.

Columbia Club Ballroom

This new feature will be introduced to the annual convention by the Indiana State Medical Association and the Indiana Chapter of the American College of Chest Physicians. These conferences consist of informal discussions with colleagues as well as with nationally and locally-known physicians interested in the subject. Ten topics will be covered and the physician may visit from one table to another asking questions, or commenting on various problems of the subject at hand. Physicians are invited to bring x-ray films and electrocardiograms to obtain the opinion of the discussors present. Complimentary refreshments will be served during the evening.

TOPICS

1. *Emphysema and Unusual Pulmonary Diseases*
2. *Pulmonary Tuberculosis and Fungous Diseases*
3. *Industrial Diseases of the Lung*
4. *Trauma of the Thorax*
5. *Intrathoracic Tumors*
6. *Major Arterial Disease*
7. *Congenital Heart Disease*
8. *Rheumatic Heart Disease*
9. *Coronary Disease*
10. *Cardiac Arrhythmias and Decompensation*

Photo Credits

Fabian Bachrach, Chicago; Noble Bretzman, Indianapolis; Deane, Bluffton; Edwards Photography, Fort Wayne; Gates Studio, Vincennes; Klein Studio, Milwaukee; Koehne, Chicago; Newman Kraft Studio, Rochester, Minn.; Olive Studio, Evansville; Youngflesh Photo.

Scientific Exhibits

EDWARD B. SMITH, M.D., *Indianapolis, Chairman*

HEART-IN-ACTION

Exhibitor: J. B. Roerig and Company, New York, N. Y.

The Heart-In-Action unit was designed specifically for J. B. Roerig & Co., and shows the human heart in normal rhythm. Along with the visual image, the viewer will also be able to hear the sound of the heart.

SUNLIGHT AND THE SKIN

Exhibitor: American Medical Association, Chicago, Ill.

1.) Physical Exposure Factors—This includes a map of the United States showing those areas of the country where insolation and incidence of skin cancer are the highest. The season of the year and conditions of atmosphere which influence exposure reactions are included.

2.) Pathological Reactions to the Sun's Rays—This includes a listing of those conditions caused, provoked or aggravated by the sun's rays, diseases based on light sensitivity, and exogenous sources which cause photosensitization. Photographs are included as examples to illustrate the foregoing conditions.

3.) Physiologic Reactions to the Sun's Rays—An illustration is presented which lists those reactions produced by the portion of the ultraviolet between 2900 Å to 3200 Å. Effects of chronic and acute exposures are included.

PHARMACIST: CONSULTANT TO THE PHYSICIAN

Topic: The Use of Radio-Active Isotopes in Modern Medicine.

Exhibitor: Indiana Pharmaceutical Association.

Attendant: H. George DeKay, Ph.D., School of Pharmacy, Purdue University, Lafayette.

The exhibit will depict the modern advances in the use of radioactivity in modern day medicine. It will also show how the pharmacist can best serve his physicians by bringing these newer approaches to his attention. The exhibit will be made up of the testing instruments and equipment used in checking radioactivity.

ALCOHOLISM: A BASIC APPROACH TO TREATMENT

Exhibitor: Leon Greenberg, Laboratory of Applied Biodynamics, Yale University, New Haven, Conn.

A guide to the treatment of the alcoholic which recognizes (a) that initial treatment and direction usually comes from the family physician and (b) that the alcoholic suffers from a low tension tolerance level. The aim of therapy, therefore, should be twofold: to raise the tension tolerance level, and to diminish stress situation. Avenues of therapy—social, medical, psychological, supportive—are briefly explored from the point of view of early-stage treatment. Results of supportive therapy with tranquilizing medication, a study of 67 chronic cases by the Connecticut State Com-

mission on Alcoholism and the Yale Center of Alcohol Studies, are described.

EXAMINATION OF THE COLON AND RECTUM

Exhibitor: American Cancer Society, Indiana Division, Indianapolis.

Attendants: William H. Cordell, Frederic H. Weigle, Miss Alvena Ivey.

The left panel is a translucent one divided in four parts depicting areas seen through the sigmoidoscope. Each of the four sections includes two transparencies of the types of lesions that may be found. This panel is lighted sequentially so that the viewers may follow the course of the instrument through the colon to the sigmoid.

The right panel gives some figures on the incidence of cancer at these sites and the comparative incidence between groups with and without polyps. These figures point up the possibility of cancer of the rectum and colon being 25 times greater in individuals with polyps than in those without polyps.

REPAIR OF TISSUE DEFICIENT HERNIAS BY AORTIC IMPLANTS

Exhibitor: Samuel J. Fogelson, M.D., Chicago, Ill.

Attendants: Samuel J. Fogelson, M.D. and Mrs. Margaret Fogelson.

The exhibit consists of 12 illuminated transparencies; two of these describe the procedure which consists of using lyophilized homologous human aortas as an adjunct for hernia repair; 5 describe the procedure, which consists of pre-operative use, stages and repair and post-operative condition of patient in both inguinal and large incisional hernias. Each transparency has its own illuminated cabinet with a separate wire going to an outlet which contains individual plugs, and all of these fit into one outlet.

CHEMISTRY, CHROMOSOMES, AND CONGENITAL ANOMALIES

Exhibitor: The National Foundation, New York, N. Y.; Virginia Apgar, M.D., M.P.H.

Attendant: Miss Matilda C. Smith.

The exhibit will present by means of models, diagrams, and pictures the *suggested* relationship between deoxyribonucleic acid and chromosomes as inferred from bacterial genetics and the relationship between chromosome patterns and congenital malformations.

AUTOMOTIVE CRASH INJURY RESEARCH OF CORNELL UNIVERSITY

Exhibitor: Automotive Crash Injury Research of Cornell University, New York, N. Y.

Attendant: William D. Coleman, Field Representative.

A scientific approach to auto crash injury prevention. Mechanics of research study, participating state agencies, list of various cities and states participating in program. Listing and explanation of some safety improvements built in recent automobiles resulting from this research project.

PHYSICAL THERAPY FROM BIRTH THROUGH RETIREMENT

Exhibitor: Indiana Chapter, American Physical Therapy Association, Elkhart, Ind.

This exhibit is a prefabricated display consisting of three panels supported by an aluminum tube frame. Over the central panel is a sign which reads: "American Physical Therapy Association, Indiana Chapter, Physical Therapy from Birth through Retirement."

The central panel contains a definition of physical therapy and six photographs with brief descriptions of therapy in orthopedic and neurosurgical conditions. Each side panel contains three photographs with brief descriptions of physical therapy in medicine, obstetrics, congenital abnormalities and neurology.

INDIANA FLYING PHYSICIANS ASSOCIATION

Exhibitor: Indiana Flying Physicians Association.

PROGRESS IN THE MANAGEMENT OF ESSENTIAL HYPERTENSION

Exhibitor: Garfield G. Duncan, M.D., Medical Division, Pennsylvania Hospital, Philadelphia, Pa.

Co-Exhibitors: Robert J. Gill, William K. Jenson, Brooks W. Gilmore, and Richard B. Freeman, Philadelphia.

This exhibit outlines methods of medical treatment for the four grades of hypertension and contains a graphic illustration of the pharmacological sites of action of the various drugs employed. There are several illustrations of cases responding to treatment. In addition to drug therapy, other points in the management of the hypertensive patient are mentioned.

CHEMOTHERAPY OF CANCER

Exhibitor: Raymond J. Krause, M.D., Peripheral Vascular Laboratory, Good Samaritan Hospital, Cincinnati.

Co-Exhibitors: Charles D. Hafner, M.D., Edward S. Strasser, M.D., John J. Cranley, M.D., Good Samaritan Hospital, Cincinnati.

Attendants: Drs. Krause, Hafner, Strasser, Cranley.

This exhibit will present the classification of chemotherapeutic agents used in the treatment of cancer; the criteria for the selection of patients; and the various methods of chemotherapy including intravenous, intrapleural, external carotid, hypogastric artery infusion and extremity perfusion. These methods of treatment will be illustrated by x-rays, photographs, and diagrammatic representations. There will also be a demonstration of the Barron food pump, the Sigmamotor infusion pump and extremity perfusion apparatus.

HEMOPHILIA

Exhibitor: Central Indiana District—Midwest Chapter—National Hemophilia Foundation, Indianapolis.

Attendants: Mrs. Richard W. Andrews, Mrs. Edward Powell, Mrs. Hugh Kirtland.

Exhibit consists of five panels showing the diagnosis, management and genetical pattern of hemophilia; the role of the Midwest Chapter of the National Hemo-

philia Foundation in the five midwest states it serves; and the role of the Indianapolis-Central Indiana District Area.

INDIANA EASTER SEAL SOCIETIES—PROGRAMMING FOR CRIPPLED CHILDREN AND ADULTS

Exhibitor: Indiana Society for Crippled Children and Adults, Inc., Indianapolis.

Attendants: James A. Carter, Mary Elfers.

INDIANA ASSOCIATION OF INDUSTRIAL NURSES ON THE JOB

Exhibitor: Indiana Association of Industrial Nurses, Fort Wayne, Ind.

Attendants: Ione Fly, R.N., Ruth Kelley, R.N., Helen Hendrickson, R.N., Edith Guedelhofer, R.N., Susannah Gilbert, R.N., and Clara Simminger, R.N.

Industrial Nursing—the profession which helps keep the employee well and on the job. The time when a nurse was given a first-aid kit and instructed to take care of cuts and bruises has long gone.

The industrial nurse today is an important member of the industrial health team. And though she still puts on dressings, she does a lot more besides. As a result of added duties and increased responsibilities, industrial nurses realized the need for an organization to represent and assist their profession. The Indiana Association of Industrial Nurses "On The Job" offers its members the opportunity to grow both professionally and personally.

METHODS OF RAPID RESTORATION OF INTESTINAL FLORA

Exhibitor: Robert T. Murphy, M.D., Cleveland, Ohio.

Co-Exhibitors: Joseph L. Bilton, M.D., Harold E. Cahoy, M.D., Cleveland.

1.) The administration of antibiotics is fraught with many dangers, particularly in those patients who receive antibiotics for prolonged periods of time.

2.) These complications of antibiotic treatment in a number of instances are due to a disturbance of the natural balance between man and the bacteria with which he normally exists.

3.) In correction of these antibiotic complications, which can be severe or fatal, we have implanted live lactobacilli, which are a normal inhabitant of the intestinal tract, particularly in infants. These bacteria do not produce disease but they inhibit the disease producing bacteria through their own growth and through the production of certain inhibitory antibiotic-like substances by the lactobacillus.

4.) This is actually an old method of treatment and was used near the turn of the century by the administration of yogurt; however, this has received little attention in this country although it has been used in Europe somewhat more extensively.

5.) We have used lactobacilli, given in a powder by mouth both in the prevention of antibiotic induced diarrhea and in the treatment of such diarrhea if it should occur. It has been clinically effective in both instances.

6.) The most significant use clinically would appear to be in the prevention of antibiotic-induced diarrhea and the reduction and possible elimination of a number of cases of staphylococcal enterocolitis. We feel that all patients who are receiving antibiotics for more than a very short period of time should receive viable lactobacillus acidophilous organisms in conjunction with their antibiotic.

7.) It is also effective in the treatment of enterocolitis including pseudomembranous enterocolitis.

DERMATOLOGICAL LESIONS AND DISEASES

Exhibitor: S. R. Mercer, M.D., Fort Wayne.

Attendant: S. R. Mercer, M.D.

Photographic records of various dermatological lesions and diseases.

SPECTROPHOTOMETRIC METHOD FOR THE MEASUREMENT OF TRYPSIN INHIBITOR CAPACITY OF SERUM

Exhibitor: Department of Research, Miami Valley Hospital, Dayton, Ohio.

Attendants: George M. Homer, Ph.D., Bernard J. Katchman, Ph.D., James P. Murphy.

A method for the spectrophotometric measurement of the trypsin inhibitor capacity (T.I.C.) of serum. This technic is believed to be a worthwhile improvement over previous methods for the measurement of this serum variable.^{1,2} This method, which is being prepared for publication, is more versatile than the other methods and also permits a more rapid assay of a larger number of serums per unit of time.

The trypsin inhibitor capacity of serum is determined as an indirect measurement. This is effected through the procedure of adding known amounts of crystalline trypsin to serum and then measuring the proteolytic activity of the excess trypsin on the synthetic substrate benzoyl-arginine ethyl ester (BAEE). Soybean trypsin inhibitor is used to standardize the proteolytic activity of the crystalline trypsin solutions such that the trypsin inhibitor capacity of serums may then be equated with the standardized trypsin solutions. By using a spectrophotometer with attached recorder, the rate of hydrolysis of the BAEE substrate by trypsin is used in place of a set incubation period hydrolysis as a means of evaluation of the serums. An actual demonstration of a serum assay with a recording spectrophotometer will be an essential part of this exhibit. In addition, charts explaining the step-by-step procedure and showing our accumulated data on serums from normal and diseased individuals will be presented.

1. Bundy, H. F., Mehl, J. W.: Trypsin inhibitors of human serum. Standardization, mechanism of reaction, and normal values, *J. Clin. Invest.* 37: 947, 1958.
2. Homer, G. M., Zipf, R. E., Hieber, T. E., Katchman, B. J.: The trypsin inhibitor capacity of serums in normal and diseased states. *Am. J. Clin. Path.* 34: 99, 1960.

RESPIRATORY DISTRESS IN THE NEWBORN

Exhibitors: Chas. R. McClave, M.D., Wm. H. Howard, M.D., Donald M. Hosier, M.D., Columbus, Ohio.

This exhibit sets forth a procedure for the systematic approach to the diagnosis of the newborn who is in respiratory distress.

Time is of the essence! A delay in the definitive diagnosis of an acute emergency in the newborn may mean the loss of a future useful citizen.

YOU CAN PRESCRIBE BETTER MENTAL HEALTH

Exhibitor: Indiana Association for Mental Health, Indianapolis.

Co-Exhibitor: Marion County Association for Mental Health, Indianapolis.

The local physician is the focus of efforts toward improved mental health. Essential to support of his efforts is public education aimed to help patients accept medical assistance for relief of emotional distress as readily as they now ask this help for physical pain. This educational effort should ease psychiatric hospitalization when indicated. Orienting the public and clearing the old stigma of mental illness is designed to help the doctor treat the patient as he knows best.

The literature displayed at this exhibit and available through your mental health association may serve the physician by expanding upon his personal discussion with the patient or his relatives and thus saving time and repetition through the printed word. Some of the literature displayed is free and can be made available for your waiting room. Other material more extensive or specific can be provided to the physician at a nominal charge.

Your mental health association has literature, films, speakers and workshop programs available for the education of the public in support of your efforts. It can also provide information for the physician as to the availability of clinics and specialists, types of commitment procedure and other help in behalf of the mentally ill.

PAPILLARY CARCINOMA OF THE THYROID—FACTORS OF CLINICO PATHOLOGIC IMPORTANCE

Exhibitor: William A. Hawk, M.D., Cleveland, Ohio.

Co-Exhibitors: J. B. Hazard, M.D., G. Crile, Jr., M.D., H. T. DeHaven, M.D.

Attendant: Wm. A. Hawk, M.D.

This exhibit is concerned with the various factors which may influence the biologic behavior of papillary carcinoma of the thyroid or be concerned in the development of this disorder and is based on an assessment of 300 cases. These factors are nine in number, namely, age, sex, nodular goiter, pregnancy, struma lymphomatosa, radiation, invasive implants, histological types and thyroid hormone therapy. The sex ratio of this disease varies with the age groups being four times as common in females in the 16 to 50 year age group but about equal in the childhood and older age groups. Nodular goiter appears to be infrequently associated with papil-

lary carcinoma and in a series of 209 consecutive cases struma lymphomatosa was observed only seven times. A history of irradiation in infancy and childhood was elicited in a high percentage of children with papillary carcinoma. Invasive implants from previous surgery were associated with a significantly worsened prognosis. The various histologic types of papillary carcinoma, i.e. papilliferous, follicular, mixed, with solid areas and tall cell did not appear to affect the prognosis of the disorder except with instance of the tall cell variant. This occurred in the older age group and was the most frequent type in the fatal cases. Desiccated thyroid hormone therapy appears to be a most significant modality in the treatment of this disease.

SCIENTIFIC AND MEDICAL ASPECTS OF AGING

Exhibitor: Commission on Aging, Indiana State Medical Association.

Attendant: Warren Andrew, M.D.

The exhibit will consist of charts and pictures presenting some of the changes in the body generally accepted as accompaniments of the aging process. Photomicrographs and also electron micrographs of tissues and cells will illustrate histological changes and alterations in fine structure. Recent scientific publications in this field, including books, national and international journals, monographs and reprints will be shown.

TESTS FOR ORAL DRUG UTILIZATION: SUSTAINED-ACTION TABLETS

Exhibitor: S. William Simon, M.D., Chief, Allergy Clinic, VA Center, Dayton, Ohio.

Many tablets and capsules are placed on the market by pharmaceutical firms with claims made as to the time it will take for the tablet or capsule to be absorbed. This also determines the number of hours that the patient will benefit from the medication. In certain types of capsules or tablets, called repeat action, two separate doses are included, one of which is immediately available and the other about four hours later. In sustained-action tablets or capsules, the two doses are so fixed that after about $\frac{1}{3}$ is made available immediately the other $\frac{2}{3}$ is gradually released over a period of about eight hours.

The timing on saturation availability of the contained medication is done by placing it in vessels containing artificial stomach and intestinal juices and then analyzing these at 30-minute intervals for the amount of the drug dissolved.

We show that this method can be very faulty by substituting, for the drug in tablets, a substance which shows on x-ray. The tablets claimed to be completely dissolved in 36 hours. By using various methods and then testing, a tablet which was dissolved in eight hours was formulated. The x-rays of both of these tablets are shown in the exhibit at various times in their passages through the gut.

Methods of determining the time necessary for complete availability of medication in capsules or tablets are then cited. These are: (1) Blood levels of the drug; (2) Use of artificial gastric and intestinal juices but with more nearly parallel circumstances to the living

gut; (3) by our method; and (4) by tracing with radioisotopes.

The thought is left that all tablets and capsules should be so tested and labeled not only as to how long the contained drug is absorbed but also as to the effect of aging, temperature, and climate on this process by giving a date after which the manufacturer feels the tablet or capsule cannot be relied upon to release the drug as claimed. This is known as an expiration date and now is put on antibiotic drugs, certain hormones, and vaccines.

THE ROLE OF THE FAMILY DOCTOR IN CEREBRAL PALSY

Exhibitor: United Cerebral Palsy of Indiana, Indianapolis.

Attendant: N. H. Keljik.

In this exhibit the key role of the family medical adviser in the diagnosis, treatment, and rehabilitation of the cerebral palsied patient is depicted in some detail. Where specialized treatment facilities are available, his role, in addition to the periodic assessment of the patient's medical status, becomes that of parent counselor and morale builder. Where facilities are limited his functions become specific: prompt, accurate diagnosis, utilization of basic principles of orthopedic, psychiatric and physical medicine, vocational rehabilitation.

Illustrated here by charts and drawings, these functions also include working closely with parents, school authorities, ancillary professional groups such as dentists, physical, occupational and speech therapists.

The aim—for the medical adviser and all other health professionals concerned—is providing the cerebral palsied patient with maximum opportunity for full participation in family, vocational and community life.

THE DIABETIC FOOT—A THERAPEUTIC PROBLEM

Exhibitor: William L. Lowrie, M.D., Henry Ford Hospital, Detroit.

Co-Exhibitors: Homer L. Johnson, M.D., W. Earl Redfern, M.D., John B. Bryan, M.D., Fred W. Whitehouse, M.D., Henry Ford Hospital, Detroit.

The diabetic foot is prone to develop infections, ulcer and necrosis because of uncontrolled diabetes, impaired arterial circulation and often, neuropathy. The presence of these complicating factors makes it imperative to avoid therapeutic measures which could interfere with healing and might promote an extension of the process. The lumina of the smaller arterics of the foot frequently are greatly narrowed or obliterated even in the absence of significant atherosclerosis or even when pulsations are present in the dorsalis pedis and posterior tibial arteries. In this situation, local surgical amputations may result in non-healing and extension of a gangrenous process. Conservative treatment is indicated including rest, control of diabetes and antibiotics when needed. The results of this type of therapy are illustrated in color. Unsatisfactory results from ill-advised surgery are also shown. When there is uncontrolled pain, resistant infection or too great a loss of tissue, amputation will be necessary. In many cases,

amputation below the knee can be accomplished thus affording a more serviceable prosthesis and less strain on the remaining foot.

This exhibit tries to emphasize the pertinent therapeutic points which if properly applied, will result in preservation of the feet of the diabetic. Since his foot is more vulnerable through increased susceptibility to infection, ischemia, and nerve involvement, the therapist must keep these points in mind. Proper therapy will include minimal use of local surgery plus avoidance of heat and other noxious agents. The therapist must expect healing to progress slowly, and exercise judgement tempered by patience. Education of the diabetic is paramount in the prevention of minor injuries which so often lead to serious therapeutic problems. The physician must not impede healing by over-zealous use of available medical and surgical therapy.

CHEMICAL TREATMENT OF URINARY CALCIFICATIONS; DISSOLVING URINARY CALCIFICATIONS

Exhibitor: William P. Mulvaney, M.D., Cincinnati 2, Ohio.

After many years of trial a non-irritating solvent for some urinary calculi has been formulated. It is useful in preventing and removing calcifications in the urinary tract composed of the "alkaline earths" (Calcium and magnesium salts, phosphates, carbonates and magnesium ammonium phosphates). The exhibit demonstrates its use in renal, ureteral and vesical calculi and in dealing with the indwelling catheter. Results in clinical use are shown.

NASAL INJURIES

Exhibitor: Carl B. Sputh, M.D.

Co-Exhibitors: Walter Aageson, M.D., Anderson; Lewis E. Morrison, M.D., Indianapolis.

Attendants: Carl B. Sputh, M.D., Walter Aageson, M.D., Lewis E. Morrison, M.D.

A CLINICAL STUDY OF INFANTILE COLIC

Exhibitor: Lawrence Breslow, M.D., Chicago.

A clinical study of 165 infants with classical symptoms of colic (gastro-entero-spasm) was carried out in the following manner:

1. A physical examination revealed a normal infant.
2. The feeding technique was studied to eliminate poor feeding habits as an etiological factor.
3. The quantity and caloric concentration of the formula was increased to eliminate hunger as a factor.
4. The formula was altered by the elimination of added carbohydrate. If the symptoms disappeared, the original formula was again used. A recurrence of symptoms was considered significant.
5. This procedure was repeated eliminating butter fat from the feeding.
6. The procedure was again repeated eliminating cow's milk protein from the formula.

This study revealed that in grossly 25% of the infants

the symptoms were due to carbohydrate: 25% were due to cow's milk allergy: 25% were due to psychosomatic factors: and the remainder to butter fat intolerance and other miscellaneous causes.

RENAL ARTERIOGRAPHY

Exhibitor: Erich K. Lang, M.D., Indianapolis.

Co-Exhibitors: William Niles Wishard, Jr., M.D., Myron H. Nourse, M.D., John H. O. Mertz, M.D., Indianapolis.

Attendants: George Bowers, M.D., Donald McCallum, M.D.

A method utilizing a percutaneous introduction of an arterial catheter for demonstration of the renal arteries is presented. The ease of introduction and positioning of this arterial catheter (Seldinger) is stressed. The method lends itself particularly well for the examination of arterial disease of the kidneys, demonstration of renal infarcts as well as renal tumors and retroperitoneal tumors. Typical examples for each one of these entities are given.

A TIME TO TEST

Exhibitor: Indiana Tuberculosis Association

Attendant: Richard C. Bogan, Field Counselor

This exhibit consists of two illuminated cases on legs with an overhead title illuminated.

The photo shows the administration of the Mantoux Tuberculin test, and photos showing the reactions. Material is presented which points out the value of the Tuberculin Test to practicing physicians, which includes illuminated material on the proper administration of the Tuberculin skin test.

THE USE OF TRANQUILIZERS, MOOD ELEVATORS AND PSYCHIC ENERGIZERS

Exhibitors: Philip B. Reed, M.D., and Vincent B. Alig, M.D., Indianapolis

Attendants: Philip B. Reed, M.D., and Vincent B. Alig, M.D.

This scientific exhibit displays and identifies by official as well as by proprietary name some drugs psychiatrists have found useful in the treatment of anxiety in its several disguises including that of depression.

Those defense mechanisms are outlined which most often need be considered in the treatment of the neuroses and the schizophrenias. This reminder of the dynamics of emotional and mental illness is offered through color pictures and synchronized sound.

A dozen or more drugs recently introduced in the symptomatic treatment of emotional and mental illness are rated as to their effectiveness and relative safety by experienced psychiatrists. The limitations as well as the occasionally unrecognized dangers in the use of some of these drugs and their combinations are reviewed. Clinical precautions, use of laboratory controls on therapy and the treatment of toxic reactions round out this brief review of the use of the psychopharmacologic drugs.

Technical Exhibits

Booth Company and Products

107 ABBOTT LABORATORIES

North Chicago, Illinois

Abbott Laboratories invites you to visit our exhibit. Representatives will be happy to answer any questions you may have concerning our leading products and new developments.

70 AKRON SURGICAL HOUSE, INC.

Indianapolis

Akron Surgical House will exhibit in Booth #70 at the State convention, Murat Temple, October 1961. Clarence Lippott and Ed Hallyburton will be on hand to show many new items and regular instruments and equipment.

9 AMERICAN STERILIZER COMPANY

Erie, Pa.

M. A. Gloekler, R. Peterson

The Dynapoise Physician's Table will be featured in the American Sterilizer Exhibit, Booth #9. Here physicians will have the opportunity to operate this new power examining and treatment table and thus discover for themselves why it has created so much interest throughout the country. Also on display will be Amsco Autoclaves for offices, clinics, nursing homes and first aid rooms. Comparisons may be made between the 613R Dynaclave, the new 8816M, and the 1022 Aristocrat. Technically qualified Amsco personnel will staff the Amsco Exhibit in Booth #9.

65 AMES COMPANY, INC.

Elkhart, Ind.

William Furrow

Ames Company, Inc.—Booth No. 65—will feature DECHOLIN-BB, a new therapeutic specialty, indicated for the relief of tension, spasms and stasis in functional G.I. disturbances when associated with hepatobiliary dysfunction.

Also, there will be continuous demonstrations of the many Ames standardized—simplified diagnostic tests.

52 WENDELL G. ANDERSON AND ASSOCIATES, INC., Indianapolis, Ind.

Business Consultants to the medical profession. Founded on 25 years' experience in financial administration and counseling. Bookkeeping and office routines, taxes, credit and collection counseling, personnel training, partnership and group planning, office location and layout, future financial planning.

40 AYERST LABORATORIES

New York, N. Y.

(formerly Doho Chemical Corporation, New York)

Karl Coleman

Ayerst Laboratories is pleased to exhibit Auralgan, ear medication for relief of pain in Otitis Media; also removal of Cerumen; Rhinalgan, nasal decongestant; Otosmosan, non-toxic fungicide-bactericide (gram negative-gram positive) for suppurative and aural dermatomycotic ears; Larylgan, soothing throat spray and gargle; Biotosmosan HC, the solution to the "Problem Ear," Antimicrobial, Anti-inflammatory, De-inflammatory, Anti-allergic, Anti-pruritic, (Contains Hydrocortisone).

75-76 BAKER BROTHERS

Indianapolis

Mr. and Mrs. Frank M. Jones, Tom Jones, Mrs. Donald Woods

Baker Brothers invites you to visit our booths 75 and 76 and inspect the latest and finest in invalid equipment. We would like to take this opportunity to thank you for your patronage and hope you will continue to use our service.

Mr. and Mrs. Frank M. Jones will look forward to seeing you again this year.

Booth

Company and Products

66 BAKER LABORATORIES, INC.

Cleveland, Ohio

J. M. Connor, Paul E. Moeder

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

3 BLACK & SKAGGS ASSOCIATES

Fort Wayne—Indianapolis—Battle Creek

Allison E. Skaggs, Paul D. Evans, John B. Hogan, Jerrel E. Meadors, Harold L. Neff

The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of 29 years and the largest such firm in the country are at their command.

Those in attendance at the ISMA Convention are cordially invited to stop at Booth #3 and meet experienced PM executives from the Indianapolis, Fort Wayne and Battle Creek offices.

68 THE BLUE LINE CHEMICAL COMPANY, St. Louis 2, Mo.

Ultra convenient and effective, for care of various vaginal conditions as well as routine feminine daintiness and hygiene Hygefem liquid and powder, Bluline Acid pH.—low surface tension superior cleansing action.

95 THE BORDEN COMPANY

New York 17, N. Y.

Methaline Exhibit: Extending the "Metha" principle to a wider area of topical dermatological usefulness, *new* Methatar, new Methaphor and new Methaseptic are being introduced at the Borden exhibit. A concise guide to treatment of skin disorders with "Metha" topicals is available.

Also on display are the well-established infant nutritionals, Bremil & Mull-Soy.

51 BREON LABORATORIES INC., New York 18, N. Y.

30 K. J. BROWN & CO., INC., Muncie, Ind.

110 BROOKS APPLIANCE COMPANY

Chicago, Illinois

W. C. Ayer, R. L. Ayer

The Brooks Appliance Company will exhibit and describe in detail the technic of applying the combination pressure bandages, the moist medicated Primer Bandage plus the Dalzoflex Elastic Adhesive Bandage, which are used in treating leg ulcers and phlebitis.

As distributors of Anatomical Supports, our representatives will be in attendance to answer questions and explain in detail our Sacral, Sacral-Lumbar and Dorsal-Lumbar Supports. Also, the Dr. Hackett "NATIONALLY APPROVED" "C" Sacral belt, Flexion and Extension Cervical Collar, Brooks Cervical Traction Outfit, Elastic Stocking, Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

93 BURROUGHS WELLCOME & CO. (U.S.A.) INC. Tuckahoe, N. Y.

G. C. Middleton, J. W. Bolton, M. E. McCandless, R. D. Gaiser, W. W. Wilson

You are cordially invited to visit Burroughs Wellcome & Co. (U.S.A.) Inc., booth #93 for the latest information on our products, and the newest developments from the extensive research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting will be our new topical and ophthalmic antibiotic products, as well as our 'Actifed-C' Expectorant. Our informed staff welcomes this opportunity to show you these new products.

- | Booth | Company and Products | Booth | Company and Products |
|--------------|--|------------|---|
| 79 | CAMERON SURGICAL INSTRUMENTS CO.
Chicago, Ill.
W. E. Mettler
Cameron Surgical Instruments Company will display its new Major Electrosurgical Unit for hospital use, as well as those for modern office surgery. Also showing Suction Coagulation Electrodes, Snares, Biopsy Forceps, electrically illuminated Ano-Procto-Sigmoidoscopic equipment, Vaginal Speculae, Otoscope, Mouth Gag, Transilluminators, Gastrosopes, Headlites, Binocular Loupes, Luxo Lamps, etc. | | materials for use with your patients will be on display. These materials are available, without charge, in the localities which have affiliated units. |
| 98 | CARNATION COMPANY
Los Angeles 36, Calif.
Carnation Company cordially invites you to visit Booth #98, where medical representatives will be pleased to welcome members and guests of the Indiana State Medical Association.
Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat and Carnalac are available.
Any questions pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed. | 105 | DE PUY MANUFACTURING CO., INC.
Warsaw, Ind.
C. L. Welker, Mrs. C. L. Welker, Bayne Monaghan, J. Keaton Landis
We are featuring many new products, including the F. B. Cast Cushion, an entire new type of Velcro Rib Belt, and many other products, both for the orthopedic surgeons and the general practitioner. You are cordially invited to stop by and visit with us. |
| 72 | CHICAGO PHARMACAL COMPANY
Chicago, Ill.
Forest Willis, Ken Wyatt
Featuring Urised, clinically-proven tablet for both comfortable sedation and thorough antisepsis in genito-urinary infections; Juniplex, an excellent tasting liquid tonic for all, containing essential minerals; Estrosed, tablet combining Reserpine and Ethinyl Estradiol for treatment of the menopausal syndrome; Resydess, tablet for reducing body weight without inducing nervousness or lethargy. | 59 | DESITIN CHEMICAL COMPANY,
Providence, R. I.
Charles Holub
Desitin Ointment, for treatment of burns, ulcers, diaper rash, abrasions, etc.; Desitin Powder, relieves chafing, sunburn, diaper rash, etc.; Desitin Suppositories and Rectal Ointment, relieve pain and itching in uncomplicated hemorrhoids, fissures; Desitin Baby Lotion, protective, antiseptic; Desitin Acne Cream, A non-staining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris; Desitin Cosmetic & Nursery Soap, Supermild; Desitin Suppositories with Hydrocortisone, prompt response to inflammatory conditions in proctitis, severe pruritus, edema. |
| 99 | CIBA PHARMACEUTICAL PRODUCTS, INC.
Summit, N. J.
FORHISTAL® is a new, low-dosage antiallergic and antipruritic agent. Clinically, FORHISTAL has proved highly effective in a wide range of allergic and pruritic disorders. It is well tolerated by patients of all ages, FORHISTAL is available in 4 forms of issue; Lontabs®, Tablets, Syrup and Pediatric Drops. | 81 | DICTAPHONE CORPORATION,
New York 17, N. Y.
G. I. Colombel, R. C. Woods, Scott Armstrong, R. Harvey, T. Eddy. |
| 46-47 | THE COCA-COLA COMPANY
Atlanta, Ga.
Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company, Indianapolis, Inc., and The Coca-Cola Company. | 61 | THE DIETENE COMPANY,
Minneapolis 16, Minn.
Earl Peck
Have you tasted Meritene? Meritene is the good-tasting Protein-vitamin-mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.
While there, review also our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.
Meritene and Dietene are advertised only to the Medical Profession. |
| 69 | CORECO RESEARCH CORPORATION,
New York 1, N. Y.
William Zimmerman
The Corec camera embodies the principle of electronic flash and constant automatic control of such factors as distance, aperture, field and exposure. Now, for the first time, Coreco offers a completely automatic professional clinical camera purposely designed to achieve the ultimate in surface, intra-oral and intra-tubular photography. Because of the simplicity of operation, even an inexperienced doctor or nurse can achieve consistently perfect color transparencies. | 121 | DOHO CHEMICAL CORPORATION
New York 13, N. Y.
Karl Coleman
Featuring: Auralgan, ear medication for relief of pain in Otitis Media; also removal of Cerumen; Rhinalgan, nasal decongestant free from systemic or circulatory effect; Otosmosan, non-toxic fungicide-bactericide (gram negative-gram positive for suppurative and aural dermatomycotic ears; Larylgan, soothing throat spray and gargle; Biotosmosan HC, the solution to the "Problem Ear." Antimicrobial, Anti-inflammatory, De-inflammatory, Anti-allergic, Anti-pruritic, (Contains Hydrocortisone). |
| 85 | CURTIS & FRENCH, INC.
Indianapolis 2, Ind.
Curtis & French, as usual, will have any thing and all things that are new in the medical line, as well as the new Ritter Universal Table. A factory man present to properly present the table. Don Graves, Mac McCain and Jack Curtis, will be in attendance. | 108 | EDISON VOICEWRITER—VAN AUDALL & FARRAR, INC.,
Indianapolis
C. W. VonGrimmenstein, R. L. Young, John Preston, Jerry Smith, Jim Strickland, Ray McShirley
Edison Voicewriting instruments, manufactured by Thomas A. Edison Industries, will be presented by Van Audall & Farrar, Inc., Indiana Distributors, with offices at Indianapolis, Evansville, Ft. Wayne, Lafayette and Muncie. This exhibit will feature Edison's new electronic instruments plastic disc and tape recorder types. True fidelity voice recording, so important for the use of medical terms, now becomes available to the physician and surgeon. Experienced representatives will be on hand in Booth 108 to demonstrate these instruments to you. |
| 100 | DAIRY COUNCIL
Evansville, Fort Wayne, Indianapolis, Kokomo, Peru, South Bend
You are cordially invited to visit our booth for a cold, refreshing drink of milk. Dairy Council health education | | |

Booth Company and Products

123 ENCYCLOPEDIA AMERICANA,

Grand Rapids, Mich.

Armin Eastman

Encyclopedia Americana most cordially invites you to inspect their newly revised 1961 edition featuring *Min-Max*, the self tutoring machine described by *Time Magazine* as "The first real innovation in teaching since invention of movable type during the fifteenth century." We also have a souvenir for you, without obligation.

55 ENCYCLOPAEDIA BRITANNICA,

Indianapolis

D. C. Dobbs

The latest edition of Encyclopaedia Britannica with its extensive revisions has received unparalleled acceptance. You are cordially invited to visit booth #55 at your annual convention and examine this world-renowned reference work.

113 ERDMAN MEDICAL BUILDINGS,

Madison, Wisc.

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 500 doctors are now practicing in Erdman-built Medical Buildings. Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office.

122 GEIGY PHARMACEUTICALS,

Yonkers, N. Y.

Geigy Pharmaceuticals cordially invites Members and Guests of the Association to visit its exhibit featuring TANDEARIL®, an important new development in non-hormonal anti-inflammatory therapy, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

88 GERBER PRODUCTS COMPANY,

Fremont, Mich.

Joseph P. Madigan, Bill Faucett, Thomas Bill
NEW! Gerber MODILAC . . . A complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac is milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

44 GREAT BOOKS OF THE WESTERN WORLD,
Cincinnati 31, Ohio

William Arlock, Maria Arlock

63 J. E. HANGER, INC.,

Indianapolis

Prosthetics embodying the latest developments of research and custom-designed to the individual patient's needs will be displayed at the Hanger's Prostheses booth. Your patients' requirements for either upper or lower extremity limbs can be discussed with any of the trained personnel in attendance—M. G. Manwaring, J. M. Talbert, or Charles Trott.

102 H. J. HEINZ CO.,
Pittsburgh 30, Pa.

Become acquainted with Heinz Baby Foods—over 115 varieties—Instant Cereals; Baby Juices; 100% Meats; High Meat Dimmers; Vegetables; Vegetable-Meat combinations; Fruits and Desserts. Newest of these foods are Apple-Cherry Juice; Junior Peaches with vitamin C added and Strained Creamed Corn.

At the exhibit you will see nutritional literature, pads listing our entire baby foods line.

Booth Company and Products

Foyer HOOSIER CADILLAC COMPANY, INCORPORATED

Indianapolis

Charles Marlett, Sales Mgr.; Raymond Moxley, Wholesale Mgr.; Andrew Hutchison, Robert S. Feeze, Leonard McCleaster, Stewart Bailey, Richard Huberty, Col. Harold Johnson, Donald Myers, George Patridge, Charles Rose, Ralph Stohler, Homer Stoughton.

Hoosier Cadillac Company, B. F. Donovan, president, located at 2323 North Illinois Street, Indianapolis, is displaying a typical doctor's car, a Cadillac Sixty-Two Coupe. This car, as do all Cadillacs, has as standard equipment: hydramatic drive, power steering, power brakes, windshield washer, turn signals, back-up lights, oil filter, electric clock, and is undercoated.

Also available as optional equipment are: white sidewall tires, heater, signal-seeking radio with power antenna and two speakers. Other optional equipment includes: E-Z Eye tinted glass, automatic headlamp dimmer, fog lights, power vent windows, power door locks and air-conditioning.

Hoosier Cadillac cordially invites you to inspect this fine car.

49 INDIANA BRACE SHOP,

Indianapolis 4, Ind

The Indiana Brace Shop, Inc., proudly presents their new concept in correction of tibial torsion and hip de-rotator with the use of the coil spring de-rotator. Also some new ideas in Cerebral Palsy bracing, i. e. (Indiana Control Brace), and the use of our many corrected shoes, introducing the custom mold shoes.

7 INDIANA NATIONAL BANK,

Indianapolis 9, Ind.

Merle H. Miller, Jr., Harlan H. Hinkle, John H. Kealing, Frank Case, Perry H. O'Neal, Robert M. Smith, Roger E. Mahn, Roger Kumlér

The Indiana National Bank booth will be staffed by officers from the bank's Trust Department who are specialists in the investment management and trust fields. These men are well qualified to discuss agency accounts, living trusts and estate management.

45 INDIANA SURGICAL INC.

Indianapolis 4, Ind.

Jim Traub, Al Dowd, Bob Thomas, Pete Quinn

Your visit at our booth will be appreciated. Jim Traub, Al Dowd, Bob Thomas and Pete Quinn will be on hand to show you some new items of interest. Thanks for stopping by.

120 INDIANAPOLIS PHARMACAL CO.

Indianapolis

Max P. Hull and Don R. Egbert will detail on Alpha Vite Span Caps, the company's new low-toxicity antiobesity agent with nutrition all in the one-a-day Span Cap. This antiobesity agent has little, if any, effect on the central nervous system. In addition, it is safe for the use of diabetics.

82 INTERNATIONAL LATEX CORPORATION

New York 1, N. Y.

Martin Amador, William Shannon

International Latex introduces the new Playtex Nurse which duplicates many of the principles of breast feeding. —Soft, pliable presterilized and disposable container permits air to be expelled before feeding. Baby takes in nourishing formula instead of "swallowed air."

—Natural shaped and natural action nipple promote proper sucking action.

141 LEDERLE LABORATORIES

Pearl River, N. Y.

G. E. Loset, District Manager; S. Bell, J. Berck, N. Hughes, D. Scothorn

Your Lederle representative will be on hand to serve you. He can furnish information on any Lederle product

- | Booth | Company and Products | Booth | Company and Products |
|------------|---|------------|---|
| | and is prepared to bring to bear on any of your medical problems the knowledge of the world-wide Lederle research organization. | 97 | MARION LABORATORIES, INC.
Kansas City 32, Missouri
Howard Murray, Allan Cushing
DUOTRATE: Cardiovascular problems requiring vasodilation can be effectively treated with less expense, less inconvenience and greater therapeutic effect. Duotrate PLATEAU CAPS provide a continuous method of drug release on a b.i.d. dosage—available in four dosage combinations. We invite you to visit our booth for information and reprints of current studies. |
| 106 | ELI LILLY AND COMPANY
Indianapolis
You are cordially invited to visit the Lilly exhibit located in Booth No. 106. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.
The following Lilly salesmen will be in attendance at our exhibit during the meeting: H. O. Johnson, R. Ph. (in charge of exhibit); P. A. Holsapple, R. Ph.; E. C. Horst, R. Ph. | 74 | THE S. E. MASSENGILL CO.
Bristol, Tennessee
Best wishes from Massengill to The Indiana State Medical Association for a most successful meeting.
Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature and samples will be available, should you desire them. |
| 91 | J. B. LIPPINCOTT COMPANY
Philadelphia, Pa.
J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. The publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing. | 4 | MEAD JOHNSON & COMPANY
Evansville, Ind.
The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products. |
| 96 | LOMA LINDA FOOD COMPANY
Arlington, Calif.
With the background of years of experience in perfecting a hypo-allergenic milk powder, and also a newly-developed concentrated liquid milk the protein of which is fully derived from the soybean and formulated with other essential additives to care for the needs of babies, growing children, and adults, the Loma Linda Food Company will be happy to welcome you to their exhibit. Attendants will be pleased to discuss the values of Soyalac powder and concentrated liquid. Samples of this flavorful product will be served at the exhibit. | 36 | MEBUCO, INC.
Mansfield, Ohio
Designers, Planners and Builders of Complete Medical Buildings
Norman Titus, Richard Selby
This is a package approach that will eliminate the costly planning time in preparation for your new office building. The program that has been designed by Doctors for Doctors. |
| 119 | P. LORILLARD COMPANY,
New York 17, N. Y.
R. M. Taube, J. L. Maze
P. Lorillard Company invites you to visit the Kent Cigarette Exhibit.
We are presenting the Story of Kent Cigarettes. And a big part of that story is why you'll feel better about smoking with the taste of Kent.
Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.
A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the convention. | 104 | MEDCO PRODUCTS CO., INC.
Tulsa 12, Oklahoma
Bill Kenneson
Presenting the MEDCO-SONLATOR. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a SINGLE Three-Way Sound Applicator.
The MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice. |
| 78 | MAICO HEARING SERVICE
Indianapolis 4, Ind.
G. M. Burrill, Frank Shepard
Maico of Indiana, Maico of Fort Wayne, Maico of South Bend, distributors of medical acoustical instruments, welcome all physicians and allied professions to Booth No. 78. Maico supplies 90% of all hearing test instruments in the world, as well as being foremost in fine hearing aids. Competent and courteous representatives assist in surveys of industrial noise levels and hearing conservation testing programs. | 58 | THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Ind.
Kenneth W. Moeller, A. Russell Quilhot
The Medical Protective Company offers unexcelled professional liability coverage. With exceptional proficiency in defense, so essential to your protection today, its experience in successfully handling 81,000 claims and suits during 62 years of Professional Protection exclusively is unparalleled in the professional liability field. |
| 101 | MALTBIE LABORATORIES DIVISION,
WALLACE & TIERNAN, INC.
Belleville, N. J.
Karl Werneke, Thomas Blau
Maltbie Laboratories features the unique tranquilizer compound, DORNWAL, impressively effective against tension headache and anxiety states. Also displayed are: CALDECORT, an antifungal, antibacterial, anti-inflammatory dermatologic ointment; DESENEX, for athlete's foot; NESACAINE, a safe, potent and rapid-acting local anesthetic; CHOLANS, for hepato-biliary dysfunction; and CALDESENE MEDICATED POWDER for diaper rash. | 92 | MERCK SHARP & DOHME
West Point, Pa.
L. R. Woerner, C. F. Lloyd, C. R. Dreiger, H. S. Faircloth
'LYOVAC' 'THROMBOLYSIN' fibrinolysin (human) for use to promote the dissolution of certain intravascular thrombi is featured
'ELAVIL', a potent antidepressant agent with a low degree of toxicity, and 'DECADRON,' for symptomatic treatment in patients with allergic and inflammatory disorders, are also of interest.
Technically-trained personnel will be present to discuss these and other subjects of clinical interest. |
| | | 142 | MERRILL LYNCH, PIERCE, FENNER & SMITH, INC.
Indianapolis 4, Ind. |

Booth Company and Products

41 MILEX ALPHA PRODUCTS
Morton Grove, Ill.
 Harry S. Stern, Amos B. Phelps
 The MILEX display will feature the new WIDSEAL COIL AND ARCING DIAPHRAGMS, a new concept in contraceptive technic.
 MILEX TRIMO-SAN for vaginal therapy and MILEX AMINO-CERV for cervical treatment will be demonstrated along with the other well-known Milex Gynecic specialties.
 "WHAT THE TEENAGER WANTS TO KNOW," a new title in the MILEX series of Physicians-Patients Guide Books will be of great interest to the attending physicians as well as the MILEX RHYTHM CALCULATOR.

60 MILLER SURGICAL COMPANY
Chicago 39, Ill.
 See the Miller Electro-scalpel, Mark C. The Miller Radio-therm and Miller Surgidyne (Tube & Spark Gap Unit). These cutting, coagulating and desiccating units are calibrated to do the most delicate work as well as light major surgery.
 Accessories such as snares, coagulator with smoke ejector, suction tubes and grasping forceps, also available. Also a long outstanding line of diagnostic equipment consisting of illuminated otoscopes, headlights, vaginal speculum with smoke ejector and Gorsch designed stainless steel proctoscopes and operating scopes, all sizes with magnification.
 Available also the Variable Wall Rayostat which converts battery-operated equipment to electric.

114 MODERN DRUGS, Inc.
Indianapolis
 Kenneth E. Hoy, Jr., Kenneth E. Hoy, Sr.
 Modern Drugs, Inc. will exhibit a comprehensive line of pharmaceutical products and supplies. Injectables, tablets, liquids, and ointments are offered.
 Featured will be Panzalone Cream—Doak, A NEW TOPICAL NON-CORTICOID STEROID FOR CONTROL OF INFLAMMATORY, PRURITIC AND ALLERGIC DERMATOSES.
 Modern Drugs, Inc. is celebrating its 25th anniversary serving Indiana physicians.

77 V. MUELLER & CO.
Chicago 12, Ill.
 Raymond McGuire, Mitchell Michalec
 The V. Mueller & Company (Chicago) exhibit will feature, principally, an interesting selection of fine surgical instruments—both standard and special—of particular importance to the general practitioner. A number of new items and specialties will be included in the display, which is always a worthwhile attraction.

28 THE MUTUAL BENEFIT LIFE INSURANCE CO.
Newark, N. J., Indianapolis
 Robert D. Beckmann, Richard Edwards, Norm Swanson, William T. White Jr.
 "Financial Planning for the Physician." Tax Calculator Slide Rule available at booth without obligation. Register for "Estate Planning for Physicians," other booklets, information on NSLI disability benefits.

80 MUTUAL MEDICAL INSURANCE, INC.
(The Blue Shield Plan)
Indianapolis
 L. E. Converse, R. C. Kilbourn
 Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth 80. Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public.

Booth Company and Products

25 NATIONAL DRUG COMPANY,
Philadelphia 44, Pa.
 W. R. Schertzinger, A. P. Anderson, J. H. Cohoon, J. W. Click
 Tepanil, Tepanil Ten-Tab and Orenzyme are being featured at our exhibit.
 Tepanil is a completely new compound that curbs the appetite with little or no CNS stimulation.
 Orenzyme is the first oral anti-inflammatory enzyme tablet on the market. Orenzyme is indicated for the treatment of any acute inflammatory process when swelling slows recovery.

29 NORTH AMERICAN PHARMACAL
Dearborn, Mich.
 Jack H. Marx, John Gardner
 North American Pharmacal will exhibit a complete line of tablets, liquids and injectables.
 One of our new products, Amodril Spancap for obesity control, is in a timed release capsule (8-10 hours). This capsule is an appetite depressant and has very little central nervous stimulation. Ideally suited for that patient who can't take amphetamines.

62 ORTHO PHARMACEUTICAL CORPORATION
Raritan, New Jersey
 Erik G. Tysklind, in charge; Frederick J. Verderosa, Walter R. Phillips
 The new potent anti-fungal agent, SPOROSTACIN Chlordantoin, is now available in three dosage forms for three differing indications: SPOROSTACIN Cream for monilial vaginitis; SPOROSTACIN Lotion for most forms of fungal dermatitis, and SPOROSTACIN Solution for paronychia and fungal infections of the nails. All three forms are non-staining, odorless, and have found enthusiastic patient acceptance.

6 PARKE, DAVIS & COMPANY
Detroit 32, Mich.
 Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.
 Our representative, M. O. Hollingsworth, will be in charge of this exhibit, assisted by J. P. Harshman.

83 PFIZER LABORATORIES
New York 17, N. Y.
 You are cordially invited to visit the Pfizer Laboratories' booth where our professional service representatives will be pleased to discuss the latest topics of clinical interest.

117 PHYSICAL MEDICINE DIVISION,
Midwest Imports
Hinsdale, Ill.
 Karl Hausner, Hermine Hausner
 The PHYSICAL MEDICINE DIVISION of MIDWEST IMPORTS, HINSDALE, ILLINOIS will exhibit the complete SIEMENS line, consisting of CARDIOMAT, electrocardiograph with automatic lead and speed marking and push-button control system; ULTRATHERM, short-wave diathermy machines with automatic tuning and deep-field efficiency—the most advanced in this field; SONOSTAT, ultrasonic generator featuring a dosage tabulator; various models of electro-diagnostic and stimulation generators. Also a complete line of diagnostic instruments. Few minutes at our booth will prove to be of great importance to you.

111, PITMAN-MOORE COMPANY
112 Indianapolis
 You are cordially invited to attend Pitman-Moore's booth where the newest Pitman-Moore specialty is displayed, and where experienced representatives will be in attendance.

- | Booth | Company and Products | Booth | Company and Products |
|------------|--|------------|--|
| 38 | R. J. REYNOLDS TOBACCO COMPANY
Winston-Salem, N. C.
C. A. Burgess, J. M. Herbert, R. O. Zeigler
Welcome to the R. J. Reynolds Tobacco Company Exhibit!
You are cordially invited to receive a cigarette case
(monogrammed with your initials) containing your choice
of CAMEL, WINSTON Filter, Menthol Fresh SALEM,
or CAVALIER King Size Cigarettes. | 5 | SANBORN COMPANY
Waltham 54, Mass.
David M. Beveridge, Morris V. Hale
The new SANBORN/FROMMER CELL COUNTER
as well as new ELECTROCARDIOGRAPHS of advanced
design and function together with the latest models of
other instruments for diagnostic use, will be displayed
and demonstrated at the Sanborn Company Booth No. 5.
Demonstrations and/or data will also be available on
Sanborn instruments for biophysical research—single and
multi-channel recording systems, monitoring oscilloscopes
and physiological transducers.
Qualified Sanborn representatives will be pleased to an-
swer questions and assist you with technical problems. |
| 94 | REX BUSINESS MACHINES CO.,
Indianapolis 4
The Rex Business Machines will have a complete display
of office machines including dictating machines, type-
writers, adding machines, check protectors, the new
Stenorette TD Model, and the new Telefunken, the latest
in dictating and transcribing machines which use the
magnetic tape principle will be on display for the first
time. Curt Benner will have charge of the booth. | 116 | SANDOZ PHARMACEUTICALS
Hanover, N. J.
MELLARIL—first potent tranquilizer with a selective
action (i.e.—no action on vomiting centers). This unique
action gives specific psychic relaxation with safety at all
dosage levels; TORECAN—as a sequel to the original
research which led to the synthesis of Mellaril, a tran-
quilizer relatively devoid of antiemetic activity, the
Sandoz Laboratories have now succeeded in developing
a potent antiemetic with little or no tranquilizing prop-
erties. Accordingly, this compound, TORECAN, consti-
tutes a more specific antiemetic and the results obtained
to date indicate that it is a promising agent for the
treatment of nausea and emesis of diverse etiology. |
| 86 | A. H. ROBINS COMPANY, INC.
Richmond, Va.
Bill Spangler, Pete Pasotti
For relieving many symptoms of the season's common
colds, prescribe DIMETAPP EXTENTABS and DIME-
TANE EXPECTORANT. DIMETAPP EXTENTABS
provide the unexcelled antihistaminic properties of <i>Di-</i>
<i>metane</i> plus the decongestant actions of <i>phenylephrine</i>
and <i>phenylpropanolamine</i> . With <i>glyceryl guaiacolate</i>
these same compounds form DIMETANE EXPEC-
TORANT.
For superior expectorant action alone, prescribe ROBI-
TUSSIN. And for a therapeutic multivitamin, ADABEE. | 87 | W. B. SAUNDERS COMPANY
Philadelphia, Pa.
Jerry Miller will once again be on hand with the full
Saunders line. New titles published since last year's
meeting include: Pillsbury et al.: <i>Dermatology</i> ; Sodeman:
<i>Pathologic Physiology</i> ; Mayo Clinic: <i>Diet Manual</i> ; Dripps:
<i>Anesthesia</i> ; Williams: <i>Endocrinology</i> ; and Nagan: <i>Medi-</i>
<i>cal Almanac</i> . |
| 140 | ROCHE LABORATORIES,
Nutley 10, New Jersey
W. Moore, J. Hansen, N. Smith, M. Drew
Among the products which we plan to feature are:
Librium—A therapeutic agent for superior, safer, faster
control of nervousness, anxiety, tension and other com-
mon emotional disturbances without the dulling effect or
depressant action of the tranquilizers.
Librax—A formulation of Librium and Quarzan for the
control of gastrointestinal disorders and associated emo-
tional symptoms. A convenient single-capsule formulation
of Librium, specific for all degrees of anxiety and ten-
sion, and Quarzan, the new, highly effective Roche anti-
cholinergic.
Tigacol—A compound for the symptomatic control of
vertigo and the often associated nausea and vomiting. A
convenient capsule formulation of two specific-acting
agents: Roniacol, which controls vertigo by direct relax-
ation of peripheral blood vessels and Tigan, which se-
lectively blocks emetic impulses without causing drowsi-
ness, adrenergic effects or significant hypertension. | 54 | SCHERING CORPORATION,
Bloomfield New Jersey
Rollan Perry, Edwin Leinhos, William Rosner, Robert
Cunningham, David Kauffman
You are invited to visit the Schering technical exhibit.
Products will include: Chlor-Trimeton, unsurpassed anti-
histamine; Fulvicin, the first oral antifungal antibiotic
for ringworm; Celestone, a new magnitude in anti-
inflammatory corticosteroid short-term therapy; and Tindal,
a new calming agent with mild sedative effects for the
cardiovascular patient who must slow down. |
| 50 | J. B. ROERIG AND COMPANY
New York 17, N. Y.
J. B. Roerig and Company will welcome members of
the medical profession at the company's exhibit of lead-
ing specialties and new products. Representatives will
be in attendance to answer any questions you may have.
Roerig recently introduced a number of new products
which representatives at the exhibit will describe and
give information on the results of clinical reports. | 73 | JULIUS SCHMID, INC.
New York 19, N. Y.
An interesting and informative exhibit featuring IMMO-
LIN Vaginal Cream-Jel for use without a diaphragm;
RAMSES flexible Cushioned and BENDEX Diaphragms;
RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid for
vaginal trichomoniasis therapy; and XXXX (FOUREX)
Skin Condoms, RAMSES, SHEIK and ESQUIRE
Rubber Condoms for the control of trichomonal re-infec-
tion. |
| 109 | ROSS LABORATORIES
Columbus 16, Ohio
Ross Laboratories, Manufacturer of Similac, features new
SIMILAC WITH IRON, a prepared infant formula
supplying 12 mg. of ferrous iron per quart of feeding.
SIMILAC WITH IRON is designed for use at the time
exogenous iron is indicated in infancy to support the
usual diet and to provide prophylaxis against iron de-
ficiency during the period of greatest incidence, starting
about the fourth month of life. Some additional indica-
tions for use are: placental or traumatic blood loss;
prematurity and twinning; pallor, irritability, and ano-
rexia with an unsatisfactory blood picture; prolonged
infection or diarrhea. | 118 | CLAYTON L. SCROGGINS ASSOCIATES
Cincinnati 19, Ohio
This firm has had 15 years' experience in practice man-
agement for doctors exclusively. Their representatives
are available for your convenience and are willing to
counsel with you concerning your practice and business
problems. |
| | | 10 | G. D. SEARLE & CO.
Chicago, Ill.
V. D. Applegate, Robert W. Schulz, George A. Yotter
You are cordially invited to visit the Searle booth where
our representatives will be happy to answer any questions
regarding Searle Products of Research. |

- Booth** **Company and Products**
- 71 SEVEN-UP BOTTLING COMPANY, INC.**
Indianapolis 2, Ind.
- 89 SMITH KLINE & FRENCH LABORATORIES**
Philadelphia 1, Pa.
Our representatives welcome the opportunity to discuss SK&F products with you and are always ready to be of help in any way they can. Products featured are: (1) Stelazine® Tablets; (2) Parnate® Tablets; (3) Compazine®; (4) Ornade® Spanstule capsules.
- 90 SMITH, MILLER & PATCH, INC.**
New York 10, N. Y.
C. Kyle Hughes
TEMPORTRIAD: A mild, rapid, predictable psychokinetic activator providing a lift for the lethargic patient; dispels fatigue, restores drive, and accelerates tempo for the mildly depressed, is featured; VITRON-C: Exceptionally well tolerated, effective hematinic; TRULASE: To help prevent consequences of inadequate digestion; BISTRIMATE: For recurring sore throat problems also displayed.
- 43 THE SPENCER CORSET SHOPPE,**
Indianapolis 4, Ind.
Doris C. Thompson, Mona A. E. Nevitt, Mildred Ulrich
Every Spencer Support is individually designed, cut and manufactured according to prescription needs, for men, women, or children, to assist in correction and rehabilitation.
You are cordially invited to visit the Spencer booth to see samples of our supports, or to inquire about supports for the specific requirements of individual patients.
Ask about our emergency service for patients requiring immediate supports.
- 35 E. R. SQUIBB & SONS**
New York 22, N. Y.
E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed.
At booth #35, we are pleased to present up-to-date information on these advances for your consideration.
- 48 THE STUART COMPANY**
Pasadena, Calif.
John W. Nichol, Jr., Hugh Wallace
A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products developed in our new and modern laboratories which have received international acclaim.
- 24 S. J. TUTAG & COMPANY,**
Detroit 34, Michigan
Frank Duesterbeck, Willard Fern, Shelby Crouch, Roland Jordan
S. J. Tutag & Company will exhibit CYDRIL, the new antiobesity product exhibiting low CNS stimulation properties. Information regarding other Tutag quality products will be available; and our representatives are looking forward to meeting you and answering your questions.
- 67 U. S. VITAMIN & PHARMACEUTICAL CORPORATION**
New York 17, N. Y.
John Porter
On display—ARLIDIN, the safe vasodilator drug with three unique pharmacologic actions: (1) dilates predominantly small blood vessels of skeletal muscle, (2) increases cardiac output without significant increase in pulse rate, (3) promotes greater circulating blood volume. Thus, ARLIDIN (Nylidrin HCl, NNR) is indicated in treating intermittent claudication in arteriosclerosis obliterans, thromboangiitis obliterans and diabetic vascular disease; also effective in Raynaud's Syndrome and ischemic ulcers.

- Booth** **Company and Products**
- 34 VAPONEFRIN COMPANY,**
New York 19, New York
Jack Kiely, Ronald Sugarman, Casper Pinsker, Jr., Donald Stern
VAPONEFRIN SOLUTION, 2.25% Solution of racemic epinephrine, as hydrochloride, equivalent in potency to 1.25% U.S.P. Reference Standard Epinephrine by bioassay for pressor potency, produces prompt bronchodilation for effective relief of bronchial asthma, emphysema, chronic bronchitis or other respiratory diseases; is notably free of side effects. VAPONEFRIN NEBULIZER, specially constructed to deliver particles in the desirable range of 0.5 to 3 microns for deposition in the bronchi and bronchioles.
- 103 WALLACE LABORATORIES,**
Cranbury, New Jersey
Wallace Laboratories exhibit features information on CAPLA, a new kind of drug for the treatment of hypertension. CAPLA acts specifically on the brain centers that control blood pressure, rather than indirectly or peripherally like older antihypertensives. It has proved non-toxic in clinical use, and side effects are limited to occasional cases of drowsiness, usually transient in nature.
- 53 WARNER-CHILCOTT LABORATORIES**
Morris Plains, N. J.
J. P. Kleinheiter, W. Shannon, J. Goodrich
Gelusil—the physician's antacid—for the relief of gastric hyperacidity and management of peptic ulcer. Provides two protective coating gels for prompt, prolonged relief of pain. Gelusil is all antacid in action—is non-constipating, contains no laxative.
Peritrate—A long-acting coronary vasodilator for patients with coronary artery disease—whether angina pectoris or coronary occlusion. Peritrate improves coronary blood flow, thereby increasing collateral circulation, with no significant change in blood pressure or pulse rate. Smooth onset of action virtually eliminates nitrate headache.
- 139 THE WARREN-TEED PRODUCTS COMPANY**
Columbus, Ohio
H. H. Lammey, W. C. Metcalf
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CONVENTION SECTION

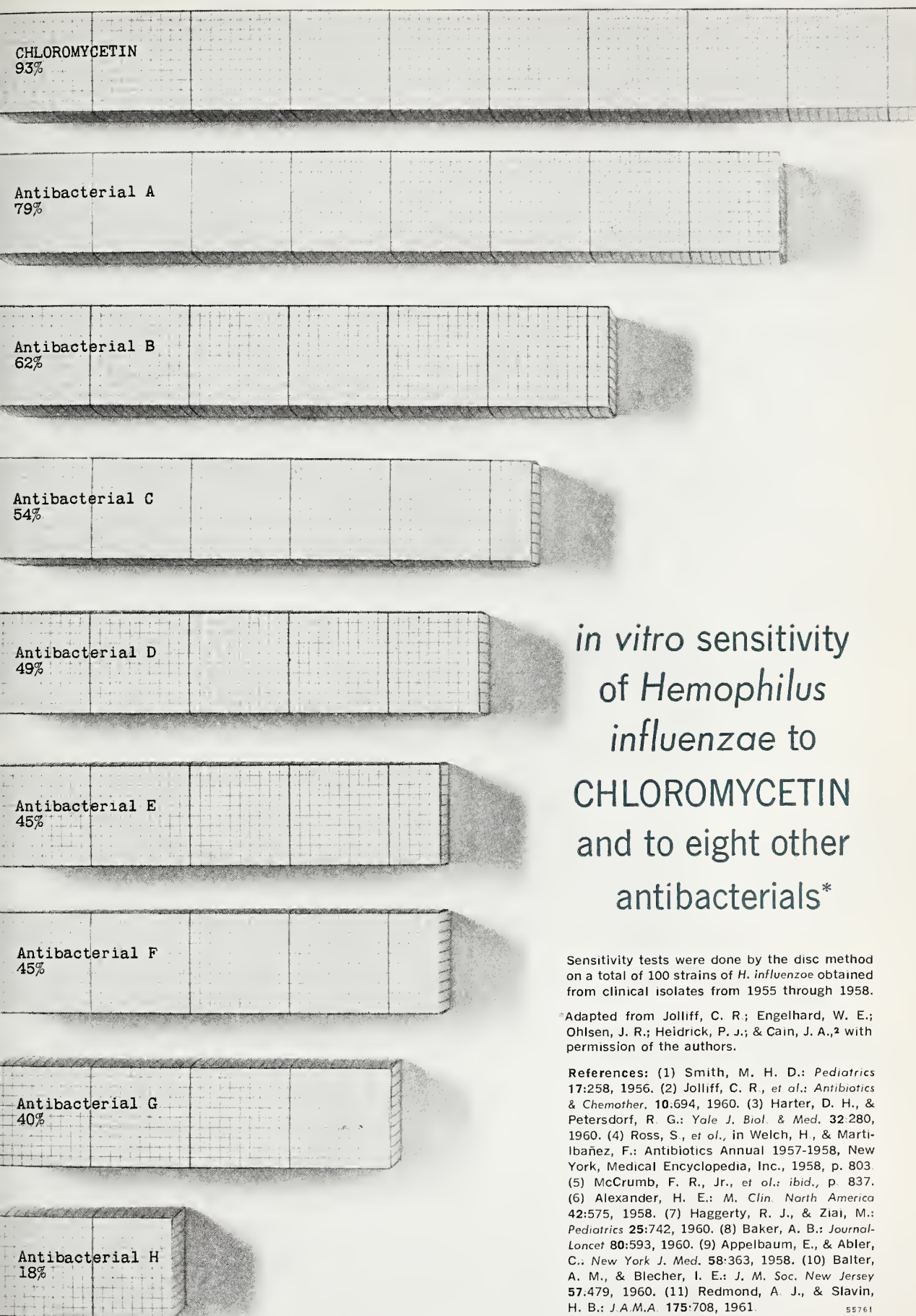
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in vitro sensitivity
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*Adapted from Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J.; & Cain, J. A.,² with permission of the authors.

References: (1) Smith, M. H. D.: *Pediatrics* 17:258, 1956. (2) Jolliff, C. R., et al.: *Antibiotics & Chemother.* 10:694, 1960. (3) Harter, D. H., & Petersdorf, R. G.: *Yale J. Biol. & Med.* 32:280, 1960. (4) Ross, S., et al., in Welch, H., & Marti-Ibañez, F.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 803. (5) McCrumb, F. R., Jr., et al.: *ibid.*, p. 837. (6) Alexander, H. E.: *M. Clin. North America* 42:575, 1958. (7) Haggerty, R. J., & Zial, M.: *Pediatrics* 25:742, 1960. (8) Baker, A. B.: *Journal-Lancet* 80:593, 1960. (9) Appelbaum, E., & Abler, C.: *New York J. Med.* 58:363, 1958. (10) Balter, A. M., & Blecher, I. E.: *J. M. Soc. New Jersey* 57:479, 1960. (11) Redmond, A. J., & Slavin, H. B.: *J.A.M.A.* 175:708, 1961.

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON—The Senate and House approved a multi-million dollar expansion of federal aid to community health services.

The Senate approved it by routine voice vote a few weeks before adjournment. The House earlier had approved a slightly different form of the legislation. No difficulty was anticipated in adjusting the differences of the two versions so that it could become effective at an early date.

Some of the programs covered by the legislation were of special importance to the aged and the chronically ill. Key provisions of the bill would:

- Raise from \$30 to \$50 million, for five years the annual authorization for matching grants to states and cities for public health services such as home nursing, home health care and a variety of services to nursing homes.

- Establish a five-year \$10 million-a-year program of special grants to non-profit groups for research and development aimed at improved health services given outside the hospital.

- Raise from \$10 million to \$20 million the annual authorization for construction of public and non-profit nursing homes.

- Extend loan provisions for hospital construction under the Hill-Burton Act until its grant program expires in June 1964.

- Raise from \$1.2 million to \$10 million the annual ceiling on grants for hospital research and permit grants for experimental or demonstration hospital units.

- Extend for three years the matching grant program which provides federal help for construction of health research facilities and authorize \$50 million rather than \$30 million a year.

INFLUENZA EPIDEMIC PREDICTED

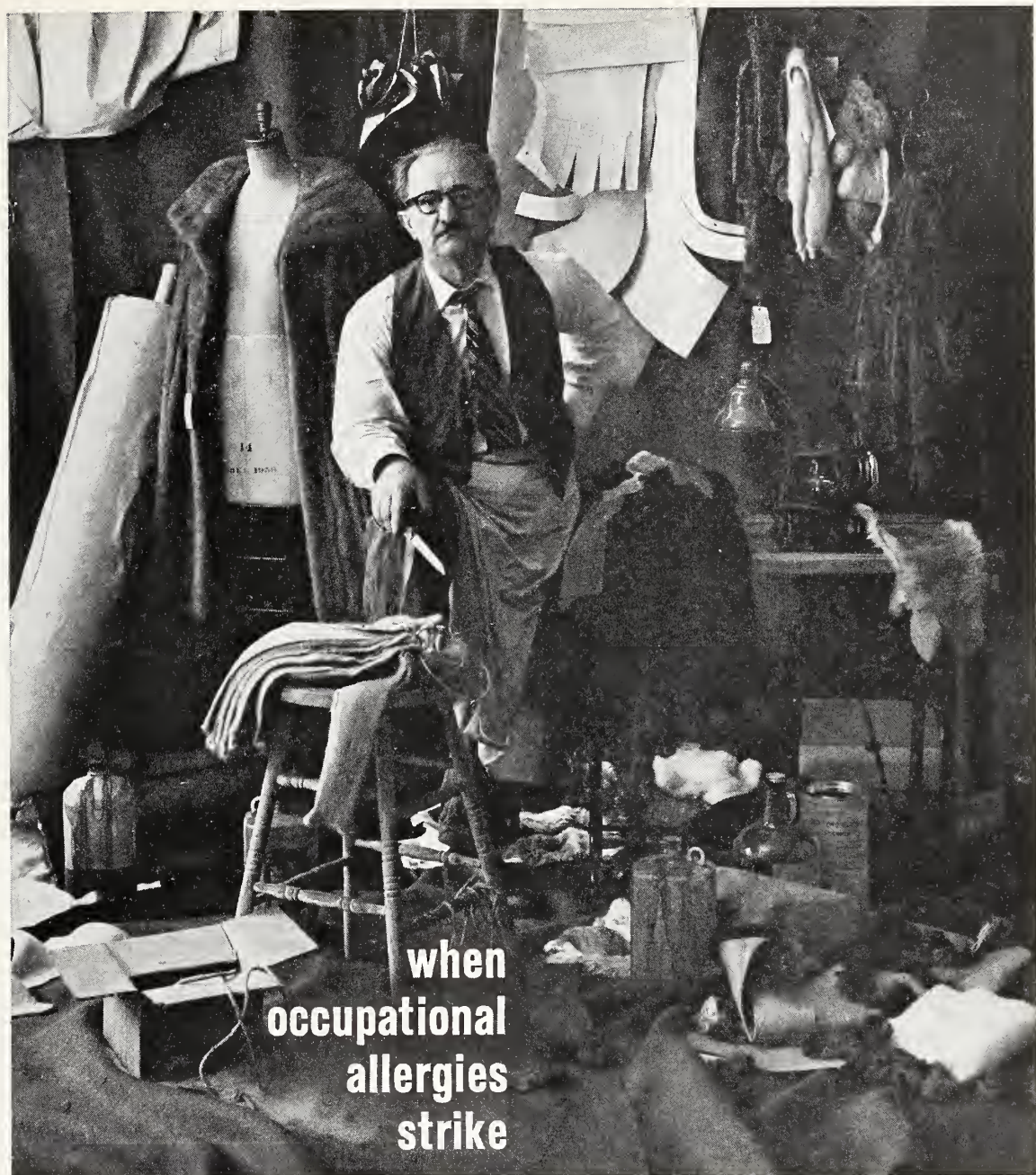
Dr. Luther L. Terry, Surgeon General of the U.S. Public Health Service, predicted that there will be a new influenza epidemic in the United States this fall and winter.

He urged immediate vaccinations for people over 65, pregnant women and persons with heart disease and other chronic illnesses.

"We are probably due for some Asian flu outbreaks, since they come in two- or three-year cycles," Terry said, "and we are overdue for Type B flu outbreaks which come in four-to six-year cycles."

More than 86,000 people in the three most susceptible groups died from influenza between September 1957 and March 1960. Asian flu has been dormant in this country since then. It has been more than six years since Type B flu has been widespread.

Continued



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MONTH IN WASHINGTON

Continued

Both types of flu were prevalent in other countries in 1960-61, especially in England. In 1951, when England had a similar epidemic, flu reached this country the following year, Terry noted.

The U.S. Public Health Service is alerting physicians, state health officers and welfare agencies to include flu shots in their programs of public assistance.

LIVE VIRUS POLIO VACCINE LICENSED

The Type I oral, live virus polio vaccine developed by Dr. Albert Sabin, has been licensed by the U.S. Public Health Service for marketing in the United States.

However, the PHS, the American Medical Association and others urged that the widest possible use still be made of the Salk killed vaccine. The principal use of the newly licensed oral vaccine this year will be against epidemic threats of Type I polio.

The license for manufacture of the oral vaccine was granted to Pfizer, Ltd., Sandwich, England, and it is being marketed in this country by Chas. Pfizer & Co., Inc., of New York.

Dr. Luther L. Terry, Surgeon General of the PHS, said he expected Type II oral vaccine to be licensed soon but that it would be several months before Type III would be licensed.

Pfizer is expected to have more than 50 million doses of the Type I oral vaccine available for use by next spring at the start of the 1962 polio season. For an epidemic reserve, the PHS ordered at the time of the licensing a total of 900,000 doses of the Type I vaccine in frozen form at a cost of \$81,000.

Information on the terms for obtaining vaccine from this epidemic reserve was sent to State and Territorial Health Officers. The requirements include:

At least three cases of Type I polio in the community within a month, of which two have been confirmed to be Type I by laboratory analysis.

Adequate community organization and medical leadership to insure rapid and complete coverage of the population under 50.

Agreement to make the vaccine available without charge to persons under 50.

All local requests must be channeled through State health departments.

Of the three types of polio virus, Type I has been responsible in recent years for between 60 and 70% of all paralytic polio in this country, PHS said. However, a sampling of virus isolated from paralytic cases this year suggests that Type III may be increasing in relative importance as a cause of paralytic disease.

Dr. Terry attributed "the progressive decline in polio since 1955" to the Salk vaccine. He said that through Aug. 5 only 234 paralytic cases had been reported this year, as compared "with 13,850 for the polio season of 1955, the first year in which the Salk vaccine became available."

The AMA said the licensing of the live virus vaccine marked "another step forward" in the fight against polio. The Association predicted the new vaccine would be "a valuable weapon against epidemics of Type I polio."

"Until such time as oral vaccines against all three types are available, the Salk vaccine remains the only protection available against all types of paralytic polio," the AMA said. ◀



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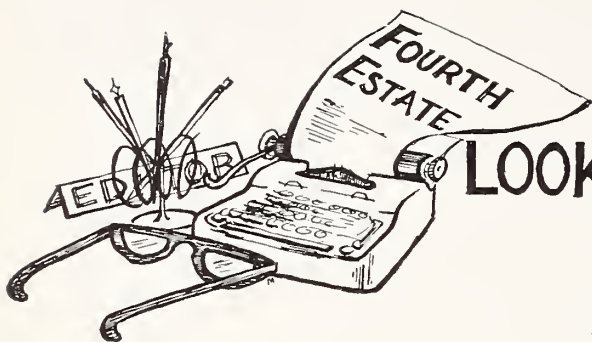
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

A Hospital Innovation

Most communities will watch with more than ordinary interest an innovation being carried out by a hospital in Winston-Salem, N. C. It is a "minimal care" building, an adjunct to the regular hospital, for patients who are convalescing or do not require complete hospital care.

The unit, a former student nurses' residence is described in the professional hospital journals. It was opened when a survey showed that at least one out of five patients did not really need the full hospital facilities.

It has been found that the minimal care unit requires only one employee for every three patients as against nearly three employees for every patient in the regular hospital.

As a result, patients pay, in some instances, only half as much for a room as they would ordinarily.

They administer their own medicines, eat in a cafeteria and have greater freedom from hospital routine.

Kokomo Tribune
August 5, 1961

It All Depends On You

Government licensing of the Sabin polio vaccine which protects against one of the three types of paralytic polio is an important and welcome development. Licensing of other types appears to be just around the corner. In fact we are being told that a complete Sabin vaccine will be available by next summer.

All of this means that the fight against paralytic polio is being won—won, that is, from the standpoint that we have the weapons to win with and are getting new ones.

But there are a couple of important facts to remember.

At the moment it is essential to bear in mind that the Salk killed virus vaccine is the only weapon effective against all three types of paralytic polio.

After that it is necessary to remember that all the preventive vaccine in the world is useless if not used. And there is no time like the present for putting on the mantle of protection.

The fact that the Sabin vaccine can be taken orally may be an important factor in getting more people to protect themselves against the paralytic effects of polio. We don't know. The Salk vaccine is administered by injection. And some folks are needle-timid.

But this is certain. The Salk vaccine has worked wonders in choking off paralytic polio. In combination, the two complete vaccines, when both are available to the public, should tip the scales in favor of total victory against a disease which only a few years ago was striking furiously in our land.

Today, more than ever before, the verdict on the ultimate fate of paralytic polio rests squarely with the public.

South Bend Tribune
Reprinted in the *Kokomo Tribune*
August 30, 1961

Coexistence of Diabetes Mellitus And Addison's Disease

ROBERT R. DAVIES, M.D.

New Castle

THE INCIDENCE of true Addison's disease has been given as one case per 100,000 population.¹ Coexistence of diabetes in Addison's disease is exceedingly rare,²⁻¹⁰ having been reported 70 times in the literature. In most instances, Addison's disease has developed in a previously diabetic patient and in only 24 instances was the reverse true.^{9,10} Both diseases may exert profound and opposite effects on carbohydrate metabolism.

Case Report

A 68-year-old white female was first examined by me in January, 1958 when she stated that she desired a general physical examination. She had had an influenzal-type illness the month preceding following which she felt tired, weak and had had considerable nausea and vague abdominal discomfort. The patient had been told sometime in the past that she had "Addison's disease."

Past history revealed that she had typhoid fever at the age of 12 and for many years during her adult life had frequent severe headaches.

In March, 1949, the patient was hospitalized for a period of three days, at which time a

diagnosis of "colitis" was made. At that time, hemogram, urinalysis and serology were negative. In 1951, she was readmitted to the hospital with a complaint of lower abdominal pain and a feeling of "pelvic pressure," symptoms which she experienced on one occasion several months before. Examination in March, 1949 revealed the skin to be "somewhat dark." Heart was normal and the blood pressure was 120/80. There were no palpable masses in the abdomen. Pelvic examination revealed a mass "the size of a small orange, which seemed to be a part of the uterus." Hemogram, blood count and serology were negative.

Exploratory laparotomy revealed multiple adhesions between the various loops of small bowel and a mass was palpated in the cervix. A total hysterectomy was done and the appendix was removed. At that time, the patient's blood pressure was 130/80. Pathological study demonstrated a benign cyst of the cervix, having the characteristics of an old endometrial cyst and chronic obliterative fibrosis of the appendix. A small fibromyoma of the uterus was also described. Following surgery the patient had a rather stormy postoperative course with abdominal distention requiring Levine suction. She

was released from the hospital improved. Subsequent to her release from the hospital she was treated for several months with "injections" which she stated caused her to "feel better."

From the time of this surgery until 1958 she had not sought medical attention.

On direct questioning, the patient denied symptoms which would suggest postural hypotension or hypoglycemia but she admitted having a poor appetite and some "indigestion" with slight nausea since her influenzal illness the month previously.

The family history disclosed the patient's husband was deceased. Her mother died of senescence, her father of "hyperthyroidism" and one brother from coronary thrombosis. At the age of 21 she had had one normal full term pregnancy with normal labor and puerperium. The child died at the age of 17 months. From the time of this delivery the patient had amenorrhea.

Physical examination revealed an elderly woman 60" tall, weighing 147½ pounds. Blood pressure in both arms, seated, was 110/70. Blood pressure after standing three minutes was 110/70, and recumbent blood pressure was 120/80. Examination revealed a generally dark complexion with darker skin and freckling over the forearms, the neck, the elbows, shoulders, forehead, face, knees, feet, and the vulvar and rectal regions. Slight areas of pigmentation could be seen in the gum line and also in the buccal mucosa opposite the second and third molar regions. Head and neck were otherwise negative. Lung fields were clear to examination and the heart was normal. Abdomen disclosed the presence of a low midline scar. On pelvic examination, the corpus and cervix were absent, and the adnexal regions were negative. Rectal examination including proctoscopic study disclosed no abnormalities. Effusion of the right knee was observed.

During hospitalization, representative blood pressures of 90/60; 110/70; 106/70; 98/58; 115/60; 110/60; 90/60; 110/60; 110/50; 100/70 and 110/60 were obtained. A first strength Mantoux test was positive (three to four plus).

White blood count was 5,700 with 1% eos, 3% stabs, 42% segs, 51% lymphs and 3% monos. Hemoglobin was 14.4 gms. Red cells appeared to be normal. Urinalysis was of insufficient quantity for specific gravity, but the

specimen was negative for albumin, sugar and formed elements. The fasting blood sugar was 124 mg%. Cardioliipin was nonreactive. Serum sodium was 130 mEq per liter; potassium 4.6 mEq per liter; chloride 104 mEq per liter. A 48-hour ACTH test was done. An initial 24-hour urine specimen contained only 2.5 mg% 17 ketosteroids, and a fasting eosinophil count was 154 per cubic mm. Twenty-five mg of ACTH was given intramuscularly and four hours later the eosinophil count had fallen only to 110 per cubic mm. Following this, the patient was given 10 mg of ACTH intramuscularly every six hours for seven doses. During the last 24-hours of this procedure, a 24-hour urine specimen was collected and the value of 17 ketosteroids was 2.4 mg%. The fasting eosinophil count at the end of this procedure was found to be 177 per cubic mm.

X-ray of the chest demonstrated a normal heart shadow, mediastinum and rib cage. Transverse diameter of the chest was 270 mm and that of the heart was 127 mm. Calcifications were seen in the hilar areas bilaterally. Flat plate of the abdomen disclosed an irregular calcified area opposite the tenth rib on the left which was felt to be due to calcification with the spleen. There was no evidence of calcification within the adrenal glands.

Definite Diagnosis Established

After a definite diagnosis of Addison's disease was established, she was advised to take cortisone, 12.5 mg twice daily.

Subsequent to this she failed to appear for an office visit, but was contacted by telephone and stated that she felt quite well. On expressing my pleasure that her medication had brought about improvement, she stated that she had been taking no drugs and had sought medical examination only for the purpose of establishing a definite diagnosis so that the Christian Science practitioner could give her proper treatment.

The patient was next seen in consultation on Feb. 18, 1959 having been hospitalized with symptoms of acute anterior chest pain. She had been hospitalized Jan. 25, 1959 by her family physician.

The patient had developed fever, sore throat and cough associated with severe pleuritic type pain along the left anterior costal margin. In addition, she developed nausea and vomiting and generalized weakness, gastrointestinal discom-

fort and had some difficulty in using her hands and feet as though they were "not under control and would not work properly." Some numbness was present in the lower extremities with a sensation of walking on "stumps." Slight edema and weakness of the hands was noticed.

Examination demonstrated pigmentation as described previously. The patient appeared to be slightly cyanotic and definitely dyspneic. Lung fields, however, were clear to examination. Examination of the heart was again noninforming. Blood pressure on admission was 80/50. Strength of hand grip was reduced bilaterally. A low midline abdominal scar was again observed. The vagina was stenotic but pelvic examination was otherwise negative. The rectum contained a large amount of feces. Peripheral pulsations were equal and active. Deep tendon reflexes were generally diminished but equal bilaterally.

Blood Tests, Urinalyses Given

The patient's cardioliipin was negative. Admitting white blood count was 8,550 with 3% eos, 3% stabs, 55% segs, 32% lymphs and 7% monos. Hematocrit was 50 cc and hemoglobin 15.4 gms. The admitting urinalysis demonstrated a trace of albumin, no sugar and was strongly positive for acetone. The specific gravity was 1.026 and the specimen contained 5-10 white cells per high power field and an occasional hyaline and granular cast. Serum sodium was 133 mEq per liter prior to treatment. Fasting blood sugar was 134 mg%. Subsequently, blood count was repeated and found to be within normal limits. Repeat urinalysis demonstrated specific gravity of 1.010, the specimen being otherwise negative. Protein-bound iodine was 6.6 mcgm%. Serum calcium was 10.4 mg%.

Three and one-half weeks following admission, x-ray of the chest revealed stable calcifications in the hilar regions with no active lesions of the lungs. Heart, mediastinum and rib cage were normal. Twenty three days after admission, a barium meal was done and was not entirely satisfactory because of the patient's inability to retain barium or to assume an upright position. No definite abnormalities were seen in the esophagus or stomach but a large diverticulum was seen to arise from the second portion of the duodenum. Large amorphous densities in the left upper quadrant were thought to be in the spleen.

Lateral x-ray of the skull was within normal limits. Electrocardiogram on Jan. 26, 1959 demonstrated a normal rhythm and rate. P-R interval was 0.21 seconds, QRS interval 0.12 seconds, QT interval 0.46 seconds. QRS complexes were widened and RSR ventricular pattern was present from V1 to V4. ST segments sagged downward in these same leads and T waves were diphasic in leads 1, 2, V1 to V6 and in AVL. T waves were flat in leads 3 and AVF. The electrocardiogram demonstrated first degree AV block, complete right bundle branch block and possible ischemia of the anterior wall. A repeat electrocardiogram on Feb. 13, 1959 was quite similar except the ST segment sagging was much less pronounced and T waves more upright in the precordial leads.

Therapy Improves Symptomatology

Treatment in the hospital consisted of 100 mg of the sodium succinate ester of hydrocortisone in an infusion of 1,000 cc of 5% glucose and saline. Hydrocortisone was then prescribed in a dosage of 20 mg four times daily, and then was reduced rapidly to 15 mg twice a day. With this therapy, there was improvement in her symptomatology. Chest pains subsided and her gastrointestinal symptoms improved. Therapy was then changed to cortisone in a dosage of 12.5 mg every 12 hours and desoxycorticosterone acetate one mg sublingually every eight hours. The patient continued to improve satisfactorily and was released from the hospital on the above regime after 42 days. Diagnoses at the time of discharge were: (1) acute pleurisy, (2) Addison's disease, (3) peripheral neuropathy, and (4) arteriosclerotic heart disease.

The patient was next seen in August, 1960 having developed increasing thirst and urinary frequency since the winter of 1960. Her weight had increased to 160 pounds and she had voluntarily gone on a diet. She had consulted a physician in another city because of her increase in weight. Examination of the urine in July had demonstrated the presence of glycosuria. The patient had no other symptoms at this time.

Physical examination in August, 1960 demonstrated a 70-year-old lady weighing 150 pounds. Blood pressure in both arms upright was 148/80. Again freckling and dark complexion of the skin was seen particularly on the dorsal surfaces of the forearms and arms,

about the neck, over the face and in the vulvar region (Figures 1 and 2). Mucous membrane pigmentation was again seen (Figure 3). Head and neck were negative to examination. The eyes, ears, nose and throat were clear. Breasts were normal. Lung fields were not remarkable. Examination of the heart demonstrated no abnormalities. A low midline abdominal scar was seen. On vaginal examination, senile vaginitis was again seen, and bimanual examination re-

vealed absence of the corpus, cervix and negative adnexal regions. Rectal examination was normal. Inspection of the back and extremities was nonrevealing. Edema, cyanosis and other abnormalities were absent and the pulses were normal. Superficial and deep tendon reflexes were equal and active.

Blood serology for syphilis was negative. White blood count was 6,700 with 2% eos. 6% stabs, 50% segs, 41% lymphs and 1% monos. Hemoglobin was 13.3 gm. Urinalysis demonstrated the specific gravity to be 1.017. No albumin was present. There was a four plus positive reaction for sugar. A trace of acetone was detected. Microscopic examination demonstrated no abnormalities. The glucose tolerance curve, using the oral route, demonstrated a fasting blood sugar of 260 mg% at which time a trace of sugar was present in the urine. In one hour the blood sugar was 460 mg% and urinary sugar was four plus, and in two and one-half hours, blood sugar was 506 mg% and urinary sugar was four plus. Total serum bilirubin was 0.5 mg%. Bromsulfalein retention at the end of 45 minutes was 4%. Alkaline phosphatase was 3.7 units. Total protein was 6.25 gm, the albumin being 4.60 gm and the globulin 2.25 gm. Cephalin cholesterol flocculation was negative in 48 hours. Protein-bound iodine was 4.4 mcgm% and the serum iron was 153 mcgm%.

Progress x-ray of the chest and electrocardiogram demonstrated no change since February, 1959.



FIGURE 1

INCREASED SKIN pigmentation can be seen about the eyes, over the forehead and in the neck region.



FIGURE 2

INCREASED PIGMENTATION of the patient's digits and nails (left) are contrasted with normal skin pigmentation (right).



FIGURE 3

MUCOUS MEMBRANE pigmentation is best seen in the gum line overlying the second molar.

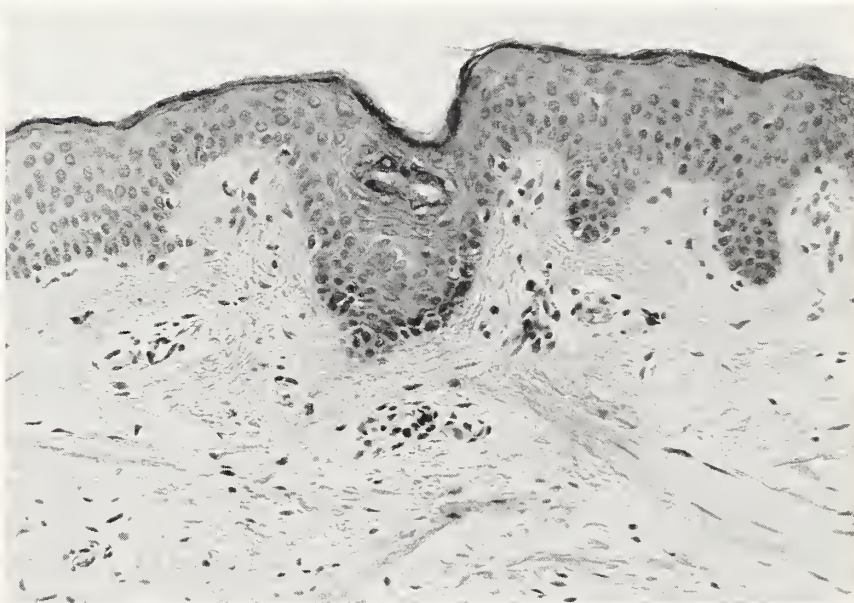


FIGURE 4

THIS SECTION of skin biopsy shows an increased deposition of melanin pigment chiefly in the basal layer.

Increased Melanin Pigment

Skin biopsy from the left arm demonstrated an increased melanin pigment content within the basal layer of the epidermis. In focal areas, hyperpigmentation was seen within some of the prickle cells overlying the basal cells (Figure 4). Iron stain demonstrated no hemosiderin pigment.

At this time, the patient was placed on a diabetic diet of 150 gms of carbohydrate, 80 gms of fat and 70 gms of protein. Glycosuria became minimal on this regime and the patient was released on the fifth hospital day. On the day prior to her release, fasting blood sugar was 138 mg%. The patient was advised to con-

tinue 12.5 mg cortisone twice daily, and was to use one mg desoxycorticosterone acetate sublingually twice a day. At the time of her release from the hospital, the patient was taking 35 U of NPH insulin each morning.

Discussion

Steroids isolated from the adrenal cortex include those with androgenic effects, steroids affecting carbohydrate and intermediary metabolism and substances affecting electrolyte metabolism. In adrenocortical insufficiency, carbohydrate and intermediary metabolism is most often characterized by an abnormally low fasting blood glucose, depletion of liver glycogen without depletion of muscle glycogen and a de-

creased excretion of urinary nitrogen. The latter has been interpreted as being due to decreased gluconeogenesis from protein. This is accompanied by an increased utilization of available carbohydrate and increased insulin sensitivity.¹¹ The administration of adrenal steroids oxygenated in position eleven leads to reversal of the abnormalities of carbohydrate metabolism. A metabolic antagonism seems to exist between insulin and adrenal steroids.

The modifying effects of diabetes and Addison's disease, when they coexist, have been described.⁸

When diabetes is complicated by the appearance of Addison's disease, amelioration of the diabetes occurs. This, however, is followed by general deterioration of the patient unless the adrenal insufficiency is treated. With the treatment of adrenal insufficiency the diabetes is again intensified.

The complication of Addison's disease by diabetes leads to the impression that the adrenal insufficiency is worse. This progression may respond to some extent to an increase in the dosage of salt-active steroids the latter being lost because of osmotic diuresis provoked by glycosuria. Increasing the dosage of carbohydrate-active steroid may aggravate the condition by increasing the glycosuria at which point large doses of salt-retaining steroid may not be capable of preventing the loss of salt and water. Institution of insulin therapy and proper diet, resulting in control of the diabetes, is followed by more ready control of the Addison's disease.

The symptoms of increasing anorexia, weakness, weight loss, fall in blood pressure and an increase in requirement of salt-active steroids did not develop in this patient, probably because the diagnosis of diabetes was made before such complications occurred.

The long history of Addison's disease in this woman prior to the onset of diabetes would seem to exclude the possibility of metastatic malignant disease or tuberculosis. Study of the patient did not suggest hemochromatosis. Since beginning therapy, following the last admission to the hospital (August, 1960), the patient has maintained her weight of 149 pounds, and these two disease conditions have been satisfactorily controlled although the patient is very sensitive

to insulin, a phenomenon emphasized in the literature.^{12,9}

Summary

The development of diabetes in a patient who has had Addison's disease for nine years has been described and the therapeutic dilemma emphasized.

ACKNOWLEDGMENTS

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The Clinic

New Castle, Indiana

Pulmonary Adenomatosis:

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*I*N AN AGE of therapeutic achievement and increasing opportunity for chemo-therapy, irradiation and isotope therapy of neoplastic disease, more exact diagnosis of diffuse pulmonary disease must be made. Pulmonary adenomatosis, alveolar cell carcinoma or diffuse bronchiolar carcinoma, to name a few of the names applied to this entity, must therefore be suspected and included in the table of differential diagnosis of diffuse infiltrative lesions of the lungs.

In the case to be presented the patient would allow no thought of a biopsy of the lungs. The outcome and the diagnosis finally reached at the postmortem table, are presented to make a strong case for either open chest biopsy of the lung or needle biopsy of the pleura and lung in appropriate cases.

Case Record

A 60-year-old housewife, was first seen in January of 1953 complaining of chest pains, right upper quadrant pain radiating to the right back, and extreme shortness of breath. Her illness had actually continued since 1946. She had noticed pain in the anterior lower part of the left chest and left arm with some shortness of breath. Her left hand and her feet and ankles also swelled in 1946. In 1953, she complained of pain in the left chest, left pectoral area and left arm increasing with exercise, going away only with relaxation and rest. She stated at that time that the effort required to make two beds caused her to be extremely short of breath.

The act of turning in bed caused the right upper quadrant pain to become much worse and

occasionally caused pain in the left chest also. She did not dare to put her arm above her head because it would produce pain in the left chest. She stated that she used one pillow for sleep and without motion could lie flat. She occasionally had to sit up once or twice a week with fluttering of the heart and shortness of breath.

Her past personal history was not too significant. She had had a caruncle treated in 1952, hemorrhoids injected in 1949, quinsy at age 10, and multiple very severe chest colds, but denied all other illnesses.

Her family history: Father died, age 65, of cirrhosis of the liver. Mother died, age 32, of pneumonia. One brother died in service of empyema, age 46. Another brother died, cause unknown. Two brothers died in infancy of whooping cough. There were no sisters. Her husband was 65, living and well. She had a daughter age 42, living and well, and a son, age 38, living and well, and another daughter age 35, living and well.

Systemic Review

The patient wore glasses; had no difficulty with ears or nose. She wore dentures. She had noticed a dry hacky cough for several weeks at the time of inspection in January of 1953. She had no hemoptysis, but did have occasional palpitation and tachycardia. Her appetite was fair. Bowel movements with mineral oil occasionally showed traces of bright red blood from the rectum. The genitourinary system was not remarkable. She stated that she had had an episode of vaginal bleeding for one day in this

present year of 1953. Menopause was said to have occurred at age 35. She denied discharge; her cervix had been cauterized in November of 1952. She was a Gravida III, Para III individual. Her referring doctor had been giving her Theelin, 20,000 units, twice a month for the past several months without any particular effect. Herberden's nodes were present on her hands; she had a rash on the right arm and under the breast on the right. She denied any difficulty relative to the nervous system. She smoked approximately three packs of cigarettes per week and did not use alcohol.

On physical examination, her temperature was 99°, blood pressure 100/60, weight 152 pounds and pulse 90. Examination of the head was not remarkable. The trachea was in the midline; the thyroid was not palpable; there was no significant adenopathy. The breasts were normal. The cardiac apex could not be found because of the tremendous overlying breast. The rate of the heart was quite rapid. The sounds were of poor quality although no murmurs were heard. Marked crepitant and subcrepitant rales were heard in both lung bases. The abdomen was free of masses. However, on deep palpation there was some pain in the right upper quadrant and pain in the right and left costovertebral angles. The body of the uterus was antverted, the adnexal areas were nonpalpable; there was a urethral caruncle. On rectal examination, there was a posterior thrombosed hemorrhoid. There were fairly marked varicosities of the extremities below the knees. The reflexes were normal and equal.

Urinalysis at this time was not remarkable. Red blood count 4.85 million, white count 14,500, hemoglobin 16 gms, hematocrit 41. The differential: 3 bands, 51 polys, 34 lymphs, 8 monos, 2 baso, 2 eosinophils. Platelets were present in normal numbers. A previous chest examination was investigated. It showed a metallic-like linear density in the region of the left diaphragm. The heart was slightly enlarged and there were several calcifications in both hilar regions, and a few small ones in the periphery of the right lung. The roentgenologist stated that the calcification perhaps could be in the pericardium or left diaphragm. A chest x-ray prior to the one taken in 1952, (June 11, 1946) showed well ventilated apices; both hilar areas showed numerous calcified glands and a chain of calcified glands extended from the central part of the lower lobe

toward the right hilum. The pleura was thickened along the right side of the pericardium. There was a marked fibrous infiltration and increased density in both lower lobes. This roentgenologist suggested a primary glandular tuberculosis in the hilar areas and healed adult tuberculosis in the central part of the right lower lobe. He suggested that the fibrous changes, as seen in 1946, could be secondary to hypostatic pneumonia and cardiac decompensation.

Electrocardiogram taken on 1-16-53 had changes compatible with an old anterior myocardial infarction. Blood serological examination at the same time showed a negative blood serology.

Repeat Chest Examination

On Jan. 29, 1953 a repeat examination of the chest was ordered. The report was as follows: "Both diaphragms are slightly elevated, but move freely. The cardiac silhouette is poorly outlined because of the marked increase in markings in both lower lung fields. In the region of the left diaphragm the previously reported calcified density is again well seen. The heart showed very shallow pulsations. There is a patchy area of increased density in the right upper lobe at the level of the first right anterior intercostal space. Both costophrenic angles are blunted. The thoracic cage is negative."

A gallbladder study at the same time showed no evidence of any lesion of the gallbladder. Again the roentgenologist suggested that the increased clouding and markings in both of the lungs suggested a cardiac decompensation. The patient was digitalized with Digitoxin, her pulse rate slowed to 77-80, but the rales in the bases still persisted unabated.

On 2-20-53 she became dizzy and very nauseated. This condition was unrelieved. At this time it was thought that she was a victim of digitalis toxicity and digitalization was stopped. She was then hospitalized for further study. At this time since I was still under the impression that she was a victim of cardiac decompensation, an oxygen tent was employed. This was concluded to be an error in that the patient became too acclimated to the tent and it was necessary to wean her away from the use of oxygen. On multiple sputums no acid fast bacilli were found. Her NPN was 34.5. On pleural tap the fluid obtained was bloody but there was no growth on culture and no cells could be obtained to demonstrate neoplasms. Roentgeno-

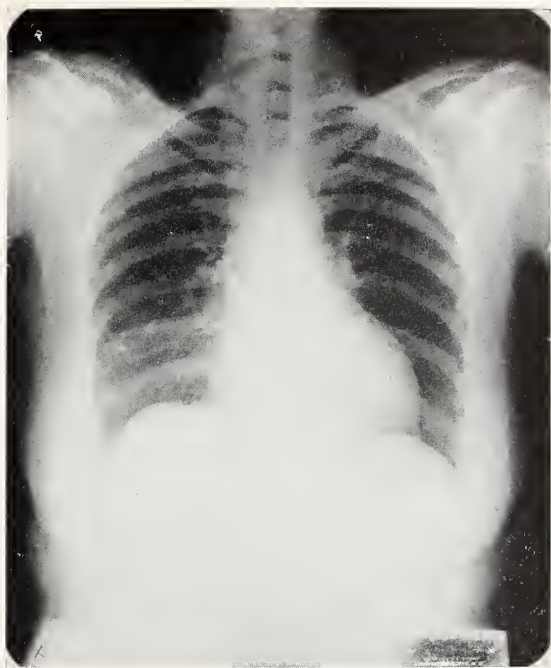


FIGURE 1

X-RAY, 4-21-52, showing cardiac enlargement, note linear calcification on left leaf of diaphragm.



FIGURE 2

FINAL X-RAY STUDY of the chest, 2-22-55, showing slowly progressive "interstitial fibrosis."

graphic studies while the patient was hospitalized did not aid the diagnosis. Electrocardiogram on 2-20-53 merely substantiated the marked digitalis effect. Intravenous pyelography on 3-7-53 did not reveal abnormality in the upper urinary tract on either side. There was normal excretion in drainage. A barium meal and barium enema on 3-9-53 did not demonstrate any abnormality. Cytological examination of the bloody pleural fluid demonstrated erythrocytes, macrophages and mesothelial cells but no tumor cells were seen.

At this time a granulomatous type of pleuro-pericarditis with involvement of both lungs was considered as one diagnostic possibility. The patient did not acquiesce to a lung biopsy and was so discharged from the hospital on Streptomycin .5 gms daily intramuscularly.

During this period of time many differential diagnostic possibilities were considered: Pulmonary fibrosis accompanying vascular disease, idiopathic pulmonary fibrosis, tuberculosis, pleuropericarditis, Boeck's sarcoid, neoplasm including lymphoma, Hodgkin's disease, diffuse bronchogenic carcinoma, various types of collagen diseases including scleroderma with pulmonary changes.

Progress films of the chest showed no change.

Blood calcium on 10-5-53 was 11 mgm%, total protein 6 gms, albumen 4.03 grams, globulin 1.97 grams. Bone marrow smears and sections showed no abnormality and there was no evidence of leukemic or tumor cell infiltration. There was no evidence of granulomatous reaction or evidence of mycotic infestation. During this period of time, acid fast studies were continuously negative. On 11-2-53 a sternal marrow culture was reported as of no growth. A final x-ray study of the chest on 2-22-55 (Figure 2) showed a slowly progressive "interstitial fibrosis" involving both lower lobes of both lungs. On 6-23-55 a vital capacity was recorded as $\frac{3}{4}$ of one liter.

Postmortem Findings

On many occasions, and again at this time, a lung biopsy was recommended with a steadfast refusal. The patient died on 9-9-55 and a post-mortem examination was obtained. On gross dissection the anatomical diagnosis were:

Arteriosclerotic heart disease including a large area of myocardial fibrosis.

Bilateral lobar pneumonia.

Mild nephrosclerosis.

However, on microscopic examination a totally

different picture resulted. The final anatomical diagnosis was one of:

Coronary sclerosis.

Fibrosis of myocardium (old and recent scars).

Bilateral pneumonitis with fibrosis and hyaline membrane formation.

Pulmonary adenomatosis.

Small fibromyomata of uterus.

Aberrant pancreas on first portion of jejunum.

The actual final diagnosis of this patient was one of pulmonary adenomatosis which contributed to the death of the patient.

Review of Literature

Pulmonary adenomatosis is gradually becoming more of a recognizable entity. It was first described by Masassez in 1876 when the first case was reported. In 1945 25 cases were reported and in 1954 Farber and others reported 217 cases and added four of their own.¹ Since that time other cases have been reported.^{14,20,21} Various terms have been used to name this entity such as cystic papillary lung tumor, mucus epithelial hyperplasia of the lung, alveolar cell tumor of the lung, diffuse primary alveolar cell carcinoma, multicentric alveolar cell carcinoma, papillary gelatinous adenocarcinoma of the lung and many others.² The fact that this disease is a variant of bronchiolar carcinoma is becoming more widespread in acceptance.^{1,22,23,20}

Swan, quoted by Brobeck, cites three criteria for the recognition of alveolar cell or pulmonary adenomatosis: (1) alveolar cellular proliferation characterized by columnar cells with cilia epithelium productive of mucus; (2) absence of an intrinsic tumor of the bronchial tree; (3) Absence of a primary adenocarcinoma in any other part of the body.³ In a review by Hutchison in 1952 a rather thorough study of the confusion regarding this disease entity was done. He points out a great deal of absence of factual evidence regarding the histogenesis of these neoplasms especially in the writings of Fried of 1925 and 1931 in which the author described in detail clinical and pathologic features of a case of primary cancer of the lung in that he thought the tumor originated in the epithelial lining of the alveoli. Hutchison further points out that Neuberger and Geever in 1942 continued to accept the theory that the original alveolar lining cell site of origin was true in spite of the array of

repudiation in 1930 by Fried that the tumor which he had originally described originated from a primary bronchogenic carcinoma. He further stated that he believed that there was no single histologic criterion by which an alveolar cell tumor could be recognized with certainty. Hutchison further took exception to the classification of alveolar cell tumors into the nodular and diffuse varieties and believed that the diffuse type merely is a confluence of a diffused nodular variety and that there is no place at all for such a classification.¹⁵

Spencer and Raeburn in 1956 examined the evidence for the bronchiolar origin of pulmonary adenomatosis. They stated that they believed the ability of bronchiolar epithelium to go into a lining of damaged alveoli had been demonstrated in five lung scars discovered during routine post-mortem examination. They believe that due to changes found in six cases of pulmonary bronchiolar adenomatosis which they had investigated, that the bronchiolar changes found in simple lung scarring and those found in benign and malignant adenomatosis of the lungs, were considered to be by them successive stages of one process. Absence of any other primary growth in the body and the possession of cilia by the tumor cells were two of the most reliable features used in establishing the diagnosis. Close resemblance of bronchiolar adenomatosis to secondary carcinoma is emphasized.

Bronchiolar adenomatosis is not infrequently multifocal and resembles a condition of Jaagsiekte in animals. They believed that bronchiolar adenomatosis showed an equal sex incidence suggesting that the etiologic factor or factors are common to both sexes.²⁰ The incidence of alveolar cell tumors of the lung, or variously called pulmonary adenomatosis, has been said by Griffith and others to be less than three percent of all surgically excised pulmonary neoplasms.¹⁷ However, many references are made to the work of Neuberger, both in affirmation and dispute, that the incidence of so-called alveolar cell tumors approximated five percent of all primary lung tumors.¹⁵ Watson and Smith²² found 33 instances of pulmonary adenomatosis in a series of 1,585 reported cases of malignant lung lesions. In a study made by Storey,²³ approximately five percent of all pulmonary carcinoma are actually adenomatosis. Metastases have been reported in a comprehensive review by Col. Lackey in 1952 of a group of 76 cases; hilar

and mediastinal nodes were invaded in 29 instances, the liver in 14 cases, the bones in six cases, the adrenal in eight, brain five, kidney five, pericardium four, spleen two, urinary bladder one, cervical nodes two, diaphragm two, peritoneum, pancreas, stomach and thyroid one case each.⁶

Throughout the literature there is always mentioned a correlated disease of sheep called "Jaagsiekte". There is a conviction of many observers that the disease is transmitted in a manner such as a virus disease, by the penning of healthy sheep with sick ones. Hence, by present standards, this disease of sheep is not a neoplastic one. The fact that metastasis through lymphatic nodes have been reported to occur in this disease however, weakens this hypothesis. There is no reason, however, to suppose that pulmonary adenomatosis is transmitted from one human being to another.¹ However, it is interesting to note that all agree that the pathologic appearance of the lungs in this disease is very close to that of pulmonary adenomatosis in the human animal. A majority of patients seen with pulmonary adenomatosis are in the so-called cancer age group although the disease has been described in a boy only 16 years old and in an 89-year-old man.

Symptoms and Signs

There is a general agreement as to the symptoms and signs of this pathologic entity. Cough is the most frequent symptom. Dyspnea accompanying the cough seems to be all out of proportion to the cough and the amount of sputum with the exception of one case in which the patient had a bronchorrhea.^{10,4,3,1} The cough is productive of a thick mucoid sputum which varies in consistency. There may be pain in the chest which may be mild in degree and variable in location. The sputum is occasionally blood streaked. Hemoptysis is not common. Weight loss is not particularly noted.

Diagnosis

The actual diagnosis of this disease is rather difficult although numerous investigators including Papanicolaou, McDonald and Watson have commented upon the abundance of diagnostic cells in the sputum. According to Griffith and others, the cytologic examination of the sputum and bronchial washings offers the only positive pre-operative diagnostic aid. Roentgenogram of the alveolar cell tumors may simulate both inflammatory and neoplastic disease of the lungs.¹⁷

This has not always been a general agreement. For example, Brobeck³ states that biopsy offers the only true diagnosis. In his opinion, bronchoscopy is useful only to remove the excess secretion, bronchography offers no aid in diagnosis and his use of cytology is left in question. The patients do not usually have a high leucocyte count and fever is not necessarily an important symptom⁵. An interesting aid in the diagnosis of malignant pulmonary lung tumors is advanced by the thought that a change in electrophoretic serum analysis of globulins might offer some aid in the diagnosis. It is pointed out that in one case of pulmonary adenomatosis in a woman 30 years of age no cell studies of the sputum were positive; however, there was a marked gamma globulin increase which suggested a chronic infection or granulomatous process. Gamma globulin increase has been found as a common finding in cases of malignant lung tumors.

As one might expect, treatment of pulmonary adenomatosis has been varied. There is a general agreement that there is no good treatment for pulmonary adenomatosis but the possibility of complete surgical resection of the affected segment of lung. Nitrogen mustards have been found to be of no avail. Roentgen therapy, although tried in many ways, has not been found to aid the patient. Antibiotics such as Streptomycin used in the patient reported, have not altered the course of the disease. In the final analysis, most authors concur that the only hope to be offered to these patients is that of a complete surgical resection.^{18,19,3,16,17} What the experimental chemotherapeutic agents of the present may do is as yet without reliable assay. At present, if surgery is not able to conquer the disease, all patients have a steady downhill course and die in asphyxia.⁴

Discussion

The definitive working diagnosis that were placed in the records of the patient reported herewith, following her first hospitalization were those of: (1) a diffuse basilar type of granulomatous disease most likely tuberculosis, or: (2) a diffuse type of neoplastic disease of the lungs. Since this patient at no time would permit a direct pulmonary biopsy and since all tests of the bone marrow, of the sputum, of the tissue fluids and of the bloody pleural fluid obtained on two occasions, failed to reveal pathologic evidence of the basic nature of this disease, the basic outcome of the case was inevitable. Follow-

ing her hospitalization in March of 1953, a long course of Streptomycin therapy was undertaken with no benefit. In view of the terminal diagnosis, we are not surprised.

In retrospectively examining the case history and analyzing the symptomatology it is noted that the patient had pain in the lower portion of the chest and some in the left arm which would be confused with the pains that one might expect in anginal syndrome or in coronary vascular disease. She had dyspnea which seemed to be all out of proportion to the amount of material which she could bring up by coughing but which was not out of proportion to the amount of lung tissue actually involved since in the terminal stage two thirds of each lung in the lower portions were infiltrated. In further reference to the pain, there may have been a complicating factor of anginal pain which could have well been present. (Substantiated by electrocardiographic changes as well as by the retrospective changes of myocardial fibrosis found at the autopsy table.) The ability to lie quietly in a supine position merely reflects the normal phase of the uninvolved segments of the lung and simulates the ability of the patient with emphysema to lie supine in spite of a marked respiratory inadequacy. Like many other cases of pulmonary adenomatosis, this patient did not have hemoptysis.

It can be pointed out that intensive study for neoplastic disease or disease of other portions of the body was carried out without uncovering any other factor.

It is an intriguing thought to postulate the fact that the onset of invasion of pulmonary adenomatosis had actually continued from her original difficulty in 1946. If this be true and her invasive period continued from 1946 to 1955, this would represent a total period of almost nine years of invasion finally culminating in the patient's demise. With this type of disease this may not be as unlikely as it might first seem. From review of the patient's first films, it seems hardly likely that complete surgical resection of the lower lobes of both lungs could have accomplished anything but a painful palliation high in the morbidity to the patient.

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Because of the frequency of anomalies biliary tract surgery requires good anesthesia, perfect exposure and the most careful dissection

Anatomical Considerations in Surgery of the Biliary Passage

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REMOVAL OF THE GALLBLADDER and exploration of the biliary passages is done for symptomatic disease due to stones, inflammation, obstruction and tumors. Surgery has been recommended also for the patient with stones in a gallbladder that functions well without symptoms of gallbladder disease. The recognition and removal of the gallbladder with stones in those who can tolerate surgery will avoid the possibility of gallstone colic; acute or chronic cholecystitis; hydrops, empyema, or gangrene; perforation with diffuse or localized peritonitis; obstructive jaundice, cholangitis, hepatitis, biliary cirrhosis; gallstone ileus; pancreatitis; symptomatic cardiac irregularities or carcinoma. When any of these complications or sequelae of gallbladder disease is present, an operation appropriate to the nature of the local disturbance and the condition of the patient is indicated.

The patient who submits to surgery for removal of the gallbladder should be assured of recovery and freedom from the symptoms for which the operation is performed. This is the responsibility of the surgeon. The success or failure of this venture depends on five essential matters:

1. *Diagnosis.* The presence of stones in the gallbladder is not positive evidence that gallbladder disease is responsible for the patient's

complaint. Neurologic, hematologic, arthritic, cardiac, pulmonary, or other abdominal conditions may be responsible for symptoms that simulate those of gallbladder disease. Removal of the gallbladder without recognizing other diseases that are responsible for symptoms is not apt to bring relief.

The importance of the history in evaluating the patient's complaint or of a complete physical examination with the laboratory studies necessary to establish a more complete diagnosis should be emphasized.

2. *Adequate surgery.* Incomplete removal of a diseased gallbladder or retention of a large segment of the cystic duct may be responsible for recurrence of symptoms. Failure to explore a common duct containing stones or to establish adequate patency of the ampulla when narrowed due to stones, stricture, or tumor, or failure to recognize a carcinoma of the pancreas or other adjacent viscera are reasons why symptoms persist or why new and more serious symptoms develop. Other significant and symptomatic conditions more remote from the biliary passages must not be overlooked.

The importance of abdominal exploration prior to removal of the gallbladder and of the visualization of the structures concerned in its removal must be stressed.

3. *Accidents.* Injuries to blood vessels, large or small, result in hemorrhage or liver necrosis; and injuries to the hepatic or common ducts, causing leakage of bile or obstructive jaundice,

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may be followed by prolonged disability or death.

The importance of recognizing the essential anatomy and of maintaining a positive effort to avoid an accident deserves emphasis.

4. *Complications.* Respiratory, vascular, neurologic, and other complications incidental to anesthesia and faulty preoperative and postoperative management prevent complete recovery. The postoperative incisional hernia may be more troublesome than the gallbladder disease for which surgery was performed.

The importance of preoperative care, competent anesthesia and surgery, and effective postoperative management should be emphasized.

5. *Noncalculous gallbladder disease.* Patients in this group are noted for the poor results which frequently follow cholecystectomy. It has been estimated that less than 25% are benefited by surgery. Thus, it is necessary to evaluate this group with a view to selecting for surgery those who are not relieved by appropriate medical management. Obesity, faulty eating habits and improper dietary selections must be corrected in some, while antispasmodics, antacids, bile salts, and sedatives must be given to others before relief from symptoms is obtained. Improved bowel habits, rest, relaxation, "peace and quiet" are helpful for all. A prolonged trial period of medical management will eliminate the large number in this group who are not apt to be helped by an operation. The remainder will require surgery. In this smaller group, unsuspected small stones, chronic gallbladder disease without stones, stenosis of the ampulla, chronic pancreatitis, or neoplasms may account for the patient's symptoms. Such patients will be helped after appropriate surgery is done.

This group properly should be considered under diagnosis but, more importantly, emphasis is placed on the careful selection of patients for surgery, especially of those in whom obstruction of the cystic duct or stones in the gallbladder are not demonstrated.

Operative Procedure

Abdominal wall incision: anatomic factors related to the abdominal wall incision are its size and the degree of exposure it affords. The incision should be long enough to permit a wide exposure of the field. This will allow: (1) exploration of the neighboring abdominal viscera; (2) visualization of the anatomy concerned in

the operation; and (3) manipulation necessary for removal of the gallbladder, probing of the ducts when necessary, and control of bleeding that may be due to accident or disease.

Whether the surgeon prefers the oblique, transverse, or longitudinal incision is not as important as the size of the incision. With satisfactory illumination of the field and gentle, careful retraction by an assistant who is aware of his responsibility not to injure the tissues, most of the accidents that occur can be prevented.

Incisions adapted to the contour of the abdomen take advantage of the good features of each and void the disadvantages (Figure 1). Any avoidable disability is too high a price to pay for a small, inadequate visualization of the field.

Exploration: while injuries to the ducts and blood vessels frequently are caused by inadequate or faulty exposure, many patients fail to recover completely with relief from symptoms because of inadequate exploration. In spite of what is regarded as a complete preoperative examination, some intra-abdominal pathologic conditions which produce symptoms or which interfere with recovery are not detected before surgery. Roentgen studies, too, are not always

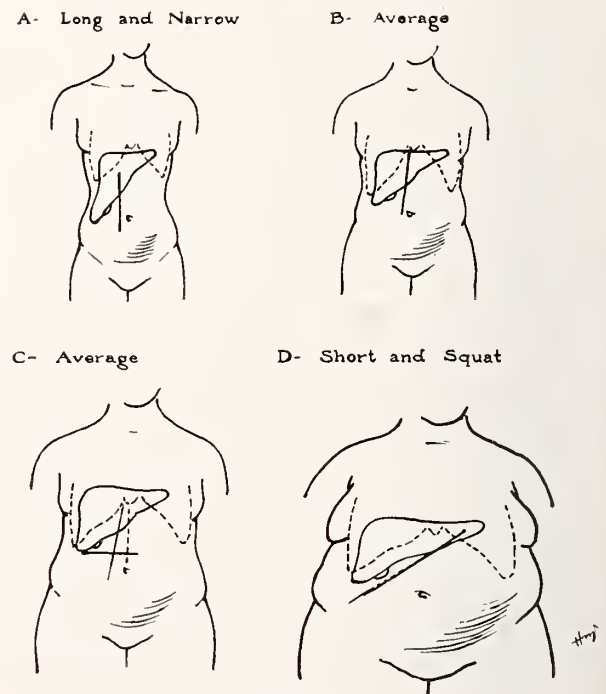


FIGURE 1

INCISION should be made to fit the configuration of the patient so as to provide ample exposure.

revealing. However, when the abdomen is opened, a visual or palpatory exploration can be made to detect significant pathologic conditions which can be corrected immediately or which indicate the need for special postoperative medical care or further surgery (Figure 2).

Exposure of blood vessels and ducts: accidents involving blood vessels and ducts may be immediately fatal or result in prolonged disability before recovery takes place. In some patients, recurrent disabling episodes ultimately result in such changes in the liver that recovery is impossible. Thus, one small error may change a prospective good result into a failure, and a patient who might have enjoyed good health is committed to a long period of disability.

A distended gallbladder is an anatomical hazard. It obscures the ducts and vessels, interferes with exploration of the regional anatomy, and adds to the danger of its removal. The distended gallbladder should be aspirated of its fluid content and emptied of its stones. This aids in visualization of the field and avoids the forceful emptying of stones into the common duct. To facilitate further exposure of the ducts and vessels, the neck of the gallbladder is elevated, and the cholecystoduodenal ligament is opened. The peritoneal edges of this opening are carefully separated until exposure of the extraperitoneal space in which the major ducts and vessels lie is sufficient. Additional mobility of the gallbladder may be obtained by incising the serosa on its lateral aspect and elevating the neck of the gallbladder from its bed in the liver. The common, hepatic, and cystic ducts may now be inspected and the cystic artery or arteries isolated.

Bleeding from torn tiny vessels which obscures the field is controlled by the application of a warm moist pad with mild compression until the field is dry. This avoids the danger of accidents.

Blood Vessels

Cystic arteries vary in number from one to four. All of them should be ligated when it is established that they enter the gallbladder. In an obscure field, the closer vessels are ligated to the gallbladder, the less the risk that hepatic vessels will be injured or occluded.

The gallbladder is held to the liver not only by its serosal covering, which is continuous with Glisson's capsule, but also by a cystic artery.

EXPLORATION PRECEDING GALLBLADDER SURGERY

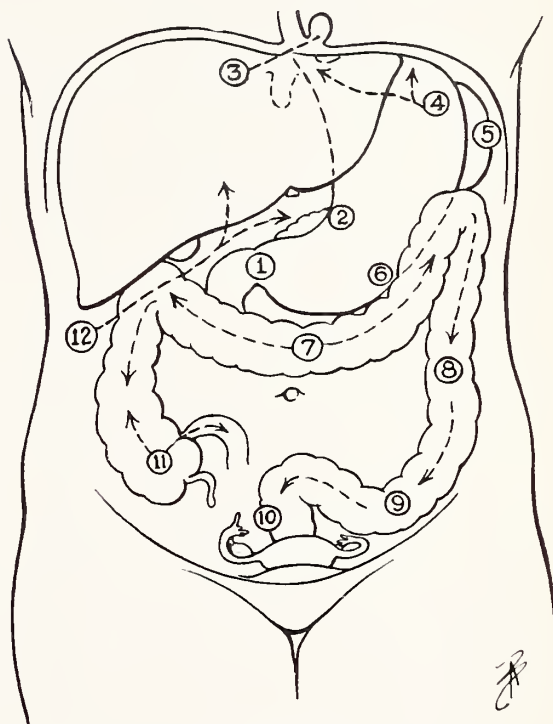


FIGURE 2

ABDOMINAL EXPLORATION should precede definitive surgery on the biliary passages. Numbered areas indicate sites where disease may be responsible for symptoms which will not be relieved by surgery on the biliary passages.

This is demonstrated by the ease with which the gallbladder is removed after the cystic artery is severed. During surgery, lateral traction on the neck of the gallbladder causes the cystic artery to become taut. It can now be palpated as a "wire" and thus identified. It lies in association with a lymph node which may obscure the view. Unless care is taken, the vessel may be torn or mistaken for a fibrous band and cut. This can be avoided by ligating the cystic artery soon after its exposure and severing it close to the gallbladder. This permits greater mobility of the neck and cystic duct with less risk of hemorrhage and a better view of the larger ducts.

The cystic artery or arteries may arise from any branch of the celiac axis of the aorta, the superior mesenteric artery, or the aorta itself. While the cystic artery comes most often from the right hepatic artery, its origin from a large vessel at some distance from the gallbladder may subject it to injury during the act of retraction

of the viscera adjacent to the gallbladder. This further emphasizes the need for care in the initial phase of cholecystectomy when the viscera are exposed and the field is opened to view. Medial and inferior displacement of the duodenum with retraction by a hand or instrument may compress a torn vessel arising from the superior mesenteric artery and prevent bleeding. After the retractor is removed, the operative field may fill with blood and prolong the procedure, or bleeding may follow closure of the abdominal wall in the early postoperative period and result in shock.

There is a particular danger when a vessel is cut or torn and retracts out of view in the field. The accumulation of blood obscures ducts and vessels, and an impulsive application of a forceps in this field in an effort to control bleeding is a frequent cause of injury to these structures.

By inserting the left index finger into the foramen of Winslow, the hepatic artery can be compressed with the left thumb in the many patients whose structural arrangement permits this to be done (Figure 3). The blood can then be aspirated and the field irrigated with isotonic salt solution. Removal of this fluid by suction clears the field. The surgeon can then see the extent of injury and secure the bleeding point.

In some patients a large right hepatic artery is more laterally placed and cannot be compressed by the maneuver indicated. Control of bleeding is effected by direct pressure on the bleeding vessels followed by suture.

Ducts

Length of the cystic duct varies considerably. Extremely short ones are less than a centimeter in length and favor injury to the hepatic and common ducts. The mildest traction on a gallbladder with a short duct favors "tenting" of the other ducts, so that the application of a clamp occludes more than the cystic duct. Other cystic ducts are as long as the gallbladder itself. Frequently, a long cystic duct and the hepatic duct lie side by side for one, several, or many centimeters before they unite to form a common duct. It is less hazardous for the patient to have the contiguous portion of the cystic duct remain, for complete excision of a cystic duct attached to the hepatic duct may be more injurious to the long hepatic duct, duodenum, or pancreas.

It is better to avoid clamping the cystic duct

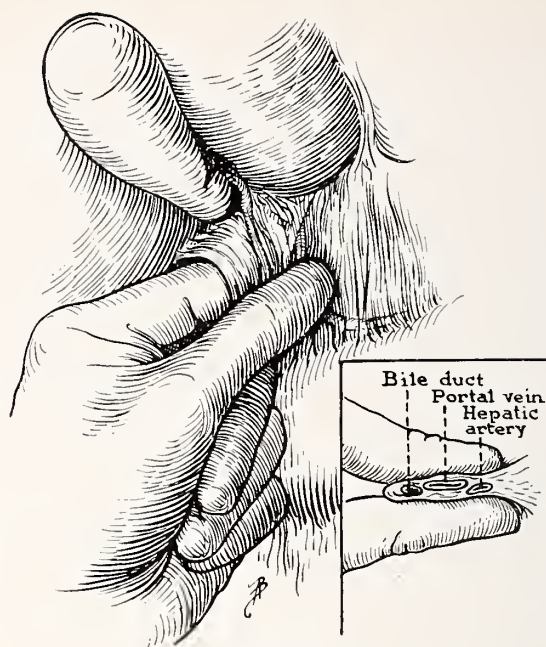


FIGURE 3

METHOD OF CONTROL of bleeding by compression of the hepatic artery when this vessel lies in its most common location. However, a right hepatic artery originating from the superior mesenteric may not be controlled by this maneuver.

in almost all instances. The duct can be exposed more readily with careful, blunt dissection, using a fine tipped Mixter forceps or any of its modifications and applying a ligature directly to the cystic duct at right angles to its axis in full view of the common and hepatic ducts.

The cystic duct usually has the narrowest caliber of all the extrahepatic ducts, and its surface is "corrugated" or irregular because of small, leaf-like projections within its lumen that extend in a spiral throughout short ducts. These are the valves of Heister, an embryologic formation usually not found in the distal end of long cystic ducts. These characteristics of the cystic duct are useful in establishing its identity on sight.

Variations in the mode of union of the hepatic with the cystic duct to form the common duct, the occasional union of the cystic with the right hepatic duct, and the right hepatic duct's rare entrance into the gallbladder warrant careful inspection before any duct is ligated and cut.

Location of the hepatic duct is constant. It lies at the bottom of the quadrate lobe of the liver. This lobe is bounded by the gallbladder fossa on the right, the round ligament on the left, the anterior margin of the liver superiorly, and the hilus, where the larger vessels enter and the hepatic duct leaves. The duct lies behind

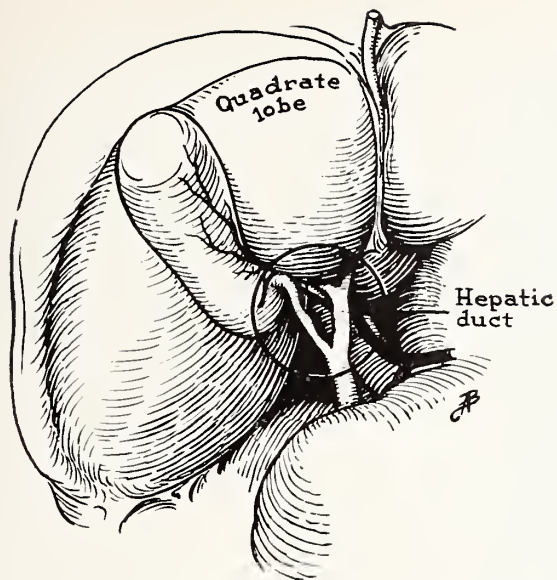


FIGURE 4

QUADRATE LOBE and the danger zone (in circle) at the bottom of this lobe.

a layer of peritoneum. Thickness of this peritoneal layer varies with the degree of chronic peritonitis associated with the biliary tract disease. Immediate exposure of the quadrate lobe by traction on the round ligament toward the left and displacement of the body of the emptied gallbladder to the right help to visualize the danger zone in biliary tract surgery (Figure 4).

Pathologic factors determine the need for exploration of the common duct. Indications are:

1. Palpable stone or stones.
2. Dilated duct—distal obstruction.
3. History of jaundice or chills and fever.
4. Thickened duct (chronic cholangitis).
5. Contracted gallbladder (stones already evacuated into common duct).
6. Large caliber cystic duct with many stones and biliary "mud" in the gallbladder (stones and "mud" in the common duct too).
7. Palpable tumor in the duodenum at the ampulla (duodenotomy indicated).
8. Gastric surgery—duodenal lesion encroaching on the common duct.
9. Chronic pancreatitis — stricture or compression of the common duct at the ampulla or in the intrapancreatic portion.
10. Postcholecystectomy. Cholangitis, pancreatitis, hepatitis, biliary cirrhosis, jaundice (in the absence of other causes for the clinical symptoms and findings), persistent biliary

fistula, persistent epigastric pain, weight loss with or without chills, fever, or jaundice.

As a safeguard in exploration, aspiration of bile is an assurance that the portal vein has not been mistaken for the duct. Mobilization of the duodenum by incision of the parietal peritoneum on its lateral margin and caudad displacement of the hepatic flexure of the colon facilitate manipulation necessary to explore the duct, expose the ampulla of Vater, or repair injured ducts.

Aberrant ducts are occasionally seen and when not involved in the removal of the gallbladder should remain undisturbed. More often, they are not recognized and may be injured during cholecystectomy. Fortunately, few of the ducts drain sufficient bile to cause serious postoperative complications. However, they account for some cases of bile peritonitis.

Abdominal "Drainage"

Bile leaking from the wound after surgery may be caused by injury to an accessory duct rather than to improper ligation of the cystic duct. This can occur even in the simplest case when the liver is partially rotated out of the abdomen and a short accessory duct is torn off. The hazard of injury to an accessory duct without knowledge that it has been torn or evulsed is present in every case.

Some of these ducts are narrow in caliber and may be injured during cholecystectomy. Subsequently, a large amount of bile may accumulate in the subphrenic or subhepatic spaces.

Careful closure of the gallbladder bed in the liver by suture of the "flaps" of the serosa and the subserosa in the liver bed helps to occlude vessels and ducts in this raw surface and assures a dry field.

Some surgeons of wide experience and good judgment do not use drains as routine practice after cholecystectomy and state that they have no cause to regret this omission. However, many others are convinced that it is better to insert a drain and risk a useless application with a good result than to omit it and risk a subphrenic accumulation of bile, blood, or peritoneal fluid.

A drain should not be a substitute for careful surgery. Hemostasis, the closure of openings in ducts, and the suture of leaking bile channels lying in the gallbladder bed of the liver prevent the accumulation of blood and bile in the subhepatic space. A hernia practically never results when the drain leaves through a stab wound on the right side below the costal margin.

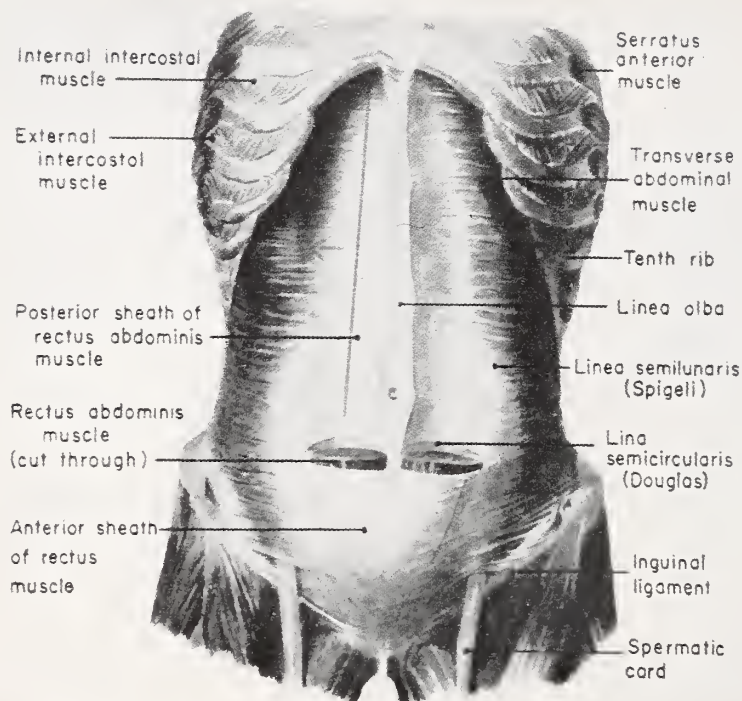


FIGURE 5
POSTOPERATIVE HERNIA-
TION frequently follows
failure to securely close the
posterior sheath of the rec-
tus muscle. This requires
muscular relaxation so that
the cut edges may be ap-
proximated.

Abdominal Wall Closure

A common hazard in gallbladder surgery is the development of a postoperative incisional hernia. This may be due to faulty healing from one or several of a variety of causes or to malocclusion of the layers of the abdominal wall. While the causes of faulty healing are well known and can be guarded against by proper nutrition, prevention of infection and avoidance of distracting forces on the suture line, the anatomic factor of complete and accurate closure of the posterior sheath of the muscle with its transversus muscle, transversalis fascia and attached peritoneum needs constant emphasis (Figure 5). Failure to suture accurately this important layer is frequently the fault of inadequate abdominal wall relaxation.

In some instances when the abdominal wall is thin, the transverse parallel fibers of the transversus muscle and its aponeurosis split apart during closure of this layer. This defective closure may be avoided by correct placement of the closing suture. A lock stitch pulled snugly at right angles to the transverse parallel fibers, while the edges of the wound are pushed toward the suture, will approximate bundles of fibers and maintain a snug closure.

Attention to the details of closure is well worth whatever additional time is required to restore the integrity of the abdominal wall. Suture materials should hold the tissues in approximation until healing is well established. Nonabsorbable sutures for fascial closures are best.

Anesthesia in an amount sufficient to relax the abdominal musculature is needed, and closure of the incised wound should not be attempted until this is established. At this stage, some anesthetists use muscle-relaxing agents to facilitate the closure. These agents are useful, but the hazard of decreased respiratory excursion and anoxia warrants constant vigilance to be sure that the patient can breathe well in the immediate postoperative period. A clear airway, with adequate oxygenation of the blood by artificial pulmonary ventilation, is a requirement until the patient regains control of respiration and is out of danger.

Summary

Surgery of the biliary passages has attained a high state of refinement. Results are excellent in most patients with biliary tract disease.

Hazards in surgery of the biliary tract are present from the moment the initial incision is

made until the last suture is placed. Pathologic changes and variations in anatomy contribute to these dangers. The location and size of the abdominal wall incision are factors that determine the ease with which surgery on the biliary passages may be accomplished. Importance of abdominal exploration to determine the presence of coincidental pathologic conditions is emphasized. In a well-exposed and illuminated field, all structures may be visualized and the risk of injury to vessels and ducts is minimized. The importance of the quadrate lobe is emphasized.

There is no substitute for care and skill. It is better to take time to perform the operation well than to hurry and risk an accident. Secure closure of the abdominal wall to prevent herniation is an essential part of the procedure.

"Postcholecystectomy syndrome" includes a variety of conditions that have been specifically described. It is not an entity and should not be referred to as such in the surgical literature. ◀

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*The Editorial Board of the Journal is pleased to announce that the following
INTERNS and RESIDENTS have been named winners of the Journal Medical
Essay Contest for 1961:*

First Prize: JOSEPH D. HOWARD, M.D.

Intern, Ball Memorial Hospital, Muncie
Title: *Fear of Death*

Second Prize: MICHAEL H. LASHMET, M.D.

Ophthalmology Resident
Indiana University Medical Center
Title: *Groenblad-Strandberg Syndrome—Case
Report and Review*

Third Prize: GEORGE F. RAPP, M.D.

Orthopedic Surgery Resident
V.A. Hospital, Indianapolis
Title: *Fat Embolism*

These papers are scheduled to appear in subsequent issues of the Journal

Local anesthesia is usually thought of by the laity as being extremely safe—Anything that may be done to prevent serious reactions is important

Local Anesthetic Drug Reactions— Their Cause and Prevention

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LOCAL ANESTHESIA is administered by every physician at some time during his practice. It is important to be aware of the basic principles which are responsible for the dangerous reactions to local anesthetic drugs. This is true, since prophylaxis is not possible, and when a reaction does occur that the error in the management of the anesthetic procedure be understood in order to avoid repetition.

Five types of reactions can occur following the administration of local anesthetic drugs.

They are:

1. Overdose reaction
2. Intolerance reaction
3. Allergic reaction
4. Vasopressor reaction
5. Psychogenic reaction

Overdose Reaction

This type of reaction, which is due to the administration of an excessive amount of local anesthetic drug to the patient, accounts for 98% or more of the systemic toxic reactions to these drugs.¹ Many therapeutic agents, which are employed in medical practice, can be lethal, if inordinate amounts are administered to the patient. They have well defined maximal doses which must not be exceeded. These amounts vary with the age and physical condition of the patient and the route of administration. Every physician is fully aware of these principles. They apply with even greater emphasis when

local anesthetic drugs are used. An overdose of local anesthetic agent may produce a rapidly fatal reaction. Ignorance, error or accident are unacceptable excuses for such a catastrophe.

The maximal doses of the local anesthetic agents, which are most frequently employed, are shown in Table I. These amounts should serve as a guide to the physician. Debilitated and cachectic patients, for example, cannot tolerate doses of drugs which are safe for the healthy adult, and the dose must be proportionately reduced for children.

Measurement of local anesthetic drugs should be made in milligrams (mgms) and not in milliliters (ml). This allows a reasonable comparison of drugs which are available in a variety of concentrations. Mathematical adeptness is not a prerequisite for this change in concept. A 1.0% solution contains 10.0 mgms per ml, and 20.0 mgms is contained in 1 ml of a 2.0% solution. Movement of the decimal point one space to the right will convert percentage concentrations into mgms per ml, and movement of the point to the left will change mgms per ml into percentage concentrations.

The toxicity of local anesthetic drugs increases by logarithmic progression, and not by arithmetic progression. Thus 120 ml of a 1.0% solution of procaine (1.2 Cms) will kill a rat in 20 minutes, but only 40 ml of a 2.0% solution (800 mgms) will produce the same effect.² It is important that the weakest concentration of drug which gives the desired degree of analgesia should be employed. A 0.5% solution of pro-

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caine or lidocaine is adequate to provide infiltration of the abdominal wall. A 2.0% solution is unnecessary and increases the danger to the patient. The maximal dose of the agent, however, should not be exceeded regardless of the concentration selected.

The systemic toxic effects of an overdose are due to the attainment of a certain concentration of the drug in the plasma. Those routes which permit the most rapid absorption allow the concentration to be reached more rapidly and with less drug. Since intravenous injection provides the most rapid entry into the blood, care must be taken during the injection to ensure that the point of the needle is not within a blood vessel. Aspiration through the syringe before the injection, or maintaining the needle in motion as the drug is injected are essential precautionary measures.

Topical anesthesia of mucus membranes is a common technic. It must be appreciated, however, that these highly vascular surfaces allow local anesthetic drugs to be absorbed almost as rapidly as when they are injected into a vein. Only small amounts of drugs, therefore can be used safely during this procedure (Table I). The atomizer, which is used to apply the solution, is a common cause of overdosage. If the anesthetic is emitted as a coarse spray, the same amount of drug will be expended more rapidly than as a fine spray, and will not cover as wide a surface area. Faulty atomizers may leak large droplets of anesthetic solution, which is ineffectual in providing anesthesia and yet increases the amount of drug which is absorbed by the patient. Again the weakest concentration which allows adequate anesthesia is the optimal concentration. It permits the use of larger volumes of solution, and larger areas of mucus membrane can be anesthetized with smaller amounts of drug. It has been asserted in the past that higher concentrations of cocaine are absorbed less readily than solutions with low concentrations. This was supposed to be due to greater vasoconstrictor action of the higher concentration. This is not true. It has been shown that a 10.0% solution is absorbed as rapidly as a 4.0% solution.³ If the amount of anesthetic agent which is placed in the atomizer bottle is less than the maximal dose, the temptation to overdose the patient can be avoided.

It is wise to avoid injecting local anesthetic drugs into inflamed areas. The injection may

**MAXIMAL DOSES, FOR HEALTHY ADULTS, OF
THE COMMONLY USED LOCAL
ANESTHETIC DRUGS**

	Subcutaneous Infiltration	Topical Application
Procaine	1000 mgm.	-----
Tetracaine (Pontocaine®) ..	100 mgm.	40-50 mgm.
Hexylcaine (Cyclaine®)	1000 mgm.	300 mgm.
Piperocaine (Metycaine®) ..	1000 mgm.	-----
Chloroprocaine (Nesacaine®) ..	1000 mgm.	-----
Lidocaine (Xylocaine®)	500 mgm.	200-250 mgm.
Cocaine	-----	150 mgm.

TABLE I

spread the infection, is painful, and the resultant anesthesia is usually poor. Of equal importance is the fact that the increased vascularity will facilitate absorption of the drug and the toxic effects will be produced more readily.

Adrenaline in concentrations of 1 in 200,000 will delay the absorption of local anesthetic drugs by producing vasoconstriction at the site of deposition of the drug. Adrenaline should be added to anesthetic solutions, if the patient's physical condition permits, whenever large amounts of drug are used, or when the area to be injected is highly vascular.

Hyaluronidase has an opposite effect to adrenaline. It facilitates the spread of the drug through the tissues and enhances absorption. The addition of hyaluronidase to anesthetic solutions has been advocated to permit the performance of satisfactory nerve blocks even when the needle has not been placed close to the nerve.⁴ The price which must be paid for this dubious aid to poor technic is more rapid absorption of the drug, and greater danger to the patient.

The rate of injection of a local anesthetic drug bears an important relationship to the rate of absorption. 2000 mgms of procaine can be injected very slowly by the intravenous route without producing any toxic reaction, whereas 1000 mgms injected rapidly into an extravascular site can produce a serious reaction. Local anesthetic drugs should be administered slowly or in divided doses, when they are applied to mucus membranes, injected into a vascular area, or when large amounts of drug are necessary.

There is some difference of opinion with re-

gard to the value of preanesthetic medication with barbiturates in the prevention of the convulsive type of reaction.⁵ It is true that heavy barbiturate sedation will prevent the appearance of the early signs of a toxic reaction, but they do not prevent the serious sequelae, such as convulsions and cardiovascular collapse. Recognition of the early signs of a reaction is important in halting the progression of a toxic reaction, since then further administration of drug can be stopped. If a reaction does occur, the cardiorespiratory depression which is produced by the barbiturates may dangerously accentuate that due to the anesthetic agent. Adequate preanesthetic sedation may be necessary for surgery with local anesthesia, but it should be appreciated that the indication is the relief of apprehension and discomfort, and not to prevent a toxic reaction.

Intolerance Reaction

There are certain individuals who are intolerant to local anesthetic drugs. Sudden cardiorespiratory collapse follows the administration of unusually small doses of drug. Fortunately this type of reaction is very rare. Investigation of most of these alleged reactions reveals that actually the patient has been overdosed with anesthetic drug. The mechanism of the intolerance reaction is probably similar to that of the overdose reaction, except that the severe central depression is produced by unusually small doses of drug. It has been suggested that this type of reaction may be due to anaphylaxis. This connotes an allergic response, and it is difficult to substantiate such a diagnosis unless some other manifestation of an allergic reaction is present. A negative preanesthetic skin test does not preclude the possibility that an intolerance reaction might occur.

Allergic Reaction

An allergic response is occasionally demonstrated by patients who have received local anesthetic drugs. They may develop dermatitis, urticaria, angioneurotic edema or asthmatic breathing. Any person who has manifested such a response should undergo a skin test before he is exposed again to these drugs. A small intradermal wheal should be raised on the flexor surface of the forearm, by injecting a small amount of the anesthetic solution through a 26 gauge needle. A control wheal using normal saline should be made on the other arm to allow

CHEMICAL GROUPS OF COMMONLY USED LOCAL ANESTHETIC DRUGS

1. Benzoic acid derivatives: cocaine, piperocaine and hexylcaine
2. Aminobenzoic acid derivatives: Procaine, tetracaine, and chloroprocaine
3. Amide: lidocaine

TABLE II

intelligent interpretation of any reaction. The patient who has an allergic sensitivity to a specific local anesthetic agent may not be sensitive to another drug with a different chemical structure (Table 2). Physicians, dentists and nurses are occasionally allergic to these and they develop dermatitis by contact with the anesthetic solutions which they use in their practice.

Vasopressor Reaction

This is also due to overdosage with a drug, but in this instance the drug is the vasopressor. When vasopressors have been added to local anesthetic solutions, the amount of the vasopressor which the patient receives must be carefully appreciated. Excessive amounts of vasopressor may produce palpitations, tachycardia, nausea and vomiting, tremors, sweating, severe headache, hypertension and cardiac arrhythmias. The injection of adrenaline during general anesthesia with cyclopropane, Fluothane®, chloroform and Trilene® is particularly dangerous, since serious cardiac arrhythmias may occur. It is advisable to refrain from using a vasopressor if the patient has severe hypertension or heart disease.

The smaller the concentration of the vasopressor which has been added to the anesthetic solution, the less the likelihood of administering an overdose to the patient. A concentration of 1 in 200,000 of adrenaline will provide optimal effects in delaying the absorption of the drug and in prolonging anesthesia. The amount of vasopressor which is added to the solution should be carefully calculated and accurately measured with a syringe.

Psychogenic Reaction

There are some patients who react dramatically to the insertion of a needle even if no anesthetic drug has been injected. Some will perspire, become pale, develop hypotension, and may even lose consciousness. Other patients will become nervous and apprehensive, hysterical and may even convulse. This reaction is readily confused

with the more dangerous reactions, if any anesthetic drug has been injected. It is safer not to make this diagnosis at the onset of symptoms, but to treat it as an overdose or intolerance reaction, rather than to waste valuable time wrestling with a difficult problem in differential diagnosis. A rapid return to the normal state will differentiate the psychogenic reaction. If local anesthesia is mandatory for this type of patient, preanesthetic sedation may be of value in preventing the reaction.

Summary

Five types of local anesthetic drug reactions have been described. The most frequent—98% or more—is due to the administration of an overdose of local anesthetic drug to the patient.

A knowledge of the underlying mechanism of these reactions, if intelligently applied, may aid in their prevention.

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Obese Children Mean Obese Adults

Obese children will probably become obese adults.

Three physicians writing in a recent issue of the *British Medical Journal*, report from a nine-year study of 98 overweight children: "There was a strong tendency for the obesity to recur after initial weight reduction and then to persist into young adult life."

The investigators advise hospitalization at the beginning of the weight reduction program in all grossly overweight children (that is, 50-60% above normal); energetic treatment, and long-term follow up to prevent relapse.

The authors were Drs. June K. Lloyd, O. H. Wolff and W. S. Whelan.

Texas State Journal of Medicine, Sept., 1961.

Characteristics of Patients at the Central Indiana Alcoholism Clinic

One of few studies dealing with
characteristics of alcoholism
in the Midwest

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IN PROPORTION to the magnitude of the social and economic problems associated with alcoholism, research on its cause and cure has been sporadic and meager. Many reasons for this may be given: among them is the fact that there is no clear-cut, widely-accepted definition of alcoholism; it is not a reportable disease such as tuberculosis, which means that the extent of the problem remains unknown. It is not a communicable disease; therefore, treatment is not mandatory, which means that the protection of the well-being of others is not assured. Finally, the stigma which has long been attached to excessive drinking is a deterrent to the alcoholic in seeking treatment, thereby reducing the opportunity for interested persons to carry out clinical research.

As in all diseases, research on prevention and cure depends on knowing how the characteristics of those with the disorder are similar to and different from the characteristics of those without the disorder and whether there are important variations in characteristics within the group having a given disease. Although research on alcoholism and alcoholics has included descriptive studies, few of them have been carried out on the alcoholic in the Midwest. This fact prompted

the writers to summarize and combine into one report the results of two studies of alcoholics known to the Central Indiana Clinic on Alcoholism. Like other studies of the characteristics of alcoholics, it describes only one segment of the alcoholic population—in the present instance, those persons who were motivated to seek treatment from the Clinic in contrast to those who went to private physicians and other professional persons, or who sought institutional treatment on an in-patient basis only, or who did not seek treatment.

The data gathered present personal and socioeconomic characteristics of 307 patients who were known to the Clinic in the first year and eight months of its operation, July 1, 1957, to March 1, 1959. Selected facts related to the history of their drinking were also secured.

Personal Characteristics

Few patients came from cities other than Indianapolis: 276 said they were residents of Indianapolis, and an additional four gave an address in Marion County. Indiana was the birthplace, however, for 146, in contrast to 148 who were born in other states, two in foreign countries, and 11 whose birthplace was unknown.

Of the 307 patients who came to the Clinic in its first 20 months of operation, 297, including 18 Negroes, were men and 10 were women. According to the formula developed by Jellinek

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FORMAL SCHOOLING COMPLETED

Amount of Schooling	Number of Patients
None	2
Eight grades or less	110
One to 4 years, inclusive, in high school	150
One but less than 4 years in college	33
Four years in college	4
Graduate study	4
Special training	2
Unknown	2
Total	307

TABLE I

there is a ratio of between five and six male alcoholics to every female alcoholic in the United States.¹ Thus, the male to female ratio in the Indiana Clinic is significantly higher.

The amount of formal schooling varied widely from none to one or more years of graduate study.

Distribution of the 307 patients according to the amount of schooling completed is presented in Table 1.

Patients with a minimum of high school education constituted 36.1%. The study by Selzer and Holloway shows that the percentage of their population with a minimum of four years of high school was 25.5.² The seemingly higher educational status of the Indiana Clinic patients may be explained by the fact that in the city of Indianapolis 39.9% of persons 25 years and older in 1950 had a high school education or more.³

In reporting their religion, 238 indicated they were Protestants, 61 were Catholic, none was of the Jewish faith, seven said they had no religion and the religion of one was not obtained. Three denominations, Baptist, Methodist and Christian, were mentioned far more frequently than 13 other denominations which were named, but the denominational preference for 104 of the Protestants was not reported.

Social Characteristics

Data on marital status at the time the patient applied to the Clinic bear out the belief that many alcoholics have marital difficulties. Table 2 indicates that only 21% were married when they came to the Clinic, although only 12% of the Clinic population had not married, and over one-half were divorced or separated.

MARITAL STATUS AT TIME OF APPLICATION TO THE CLINIC

Marital Status	Number of Patients
Married	66
Single	38
Widowed	30
Divorced	118
Separated	55
Total	307

TABLE II

Multiple marriages were reported by 89 of the 269 patients who were known to have married at least once. The United States Census shows that in the general population of Indiana of marriageable age, 3.6% were either divorced or separated, 71.3% were married, 20.5% were single, and 4.6% were widowed.⁴ When these figures are compared with those of the Clinic, the instability of the marital situations of the alcoholics in the study is at once apparent.

In a study by Straus and Bacon of a larger group of alcoholics from nine clinics, the single persons comprised 16.4% of their study population.⁵ These authors offered as an explanation for the percentage of single persons in their study the fact that homeless alcoholics who have failed to marry often do not come to clinics.⁶ This same supposition may explain the small number of single persons in the Indiana study.

Roughly two-thirds of the group had children, with one-third of the patients having either one or two children. The patients were classified according to the number of children reported and it was found that as the number of children increased, the number of patients in each category decreased. Only nine patients had six children, and only three had more than six: one each had eight, nine, and ten children.

In more than one-half of the instances where there were children, at least one child was younger than 18 years of age and in 75 families all children were under eighteen.

Data in Table 3 indicate that a sizeable number of minor children were being affected by their parent's alcoholism, and it is also probable that adult children were having to assume some responsibility for others in the family because of the problems resulting from alcoholism.

Residential Mobility and Living Arrangements

Although information on the length of time the patient had been living at his present address was not available for 74 patients, data on the others are of interest. Ninety-three patients had been at their last address for less than six months and an additional 16 had resided less than a year but a minimum of six months at their current address, making a total of 109 who had moved at least once within a year. On the other hand, 65 had lived at the same residence for periods ranging from one to five years, 28 had lived from five to ten years at their last reported address, and 31 had not moved for a minimum of ten years.

Home ties had been broken for 149, nearly one-half of the patients, since this number was living in rooming houses, "cheap" hotels, missions, railroad cars, and "here and there." This ratio contrasts sharply with the 16% of 1,930 patients who said they were roomers in the Straus and Bacon study of clinic patients.⁷ A smaller group, 83, lived in their own homes, and 55 were living with relatives. The living arrangements were not known for 20.

Employment

Data on employment provide additional evidence by which the seriousness of the problems of the alcoholic can be weighed. Excessive use of alcohol may affect the individual's ability to hold his job and may bring about deterioration in his productive capacity.⁸ This is borne out in the present study by the large number of patients, 237, who were unemployed at the time they came to the Clinic. Only 65 had employment; this information was unknown for five. The usual occupations of these patients fell primarily into the classification of semi-skilled and skilled workers, there being 174 in this category. The classification with the next largest number of patients was "unskilled" in which there were 78; 27 were salesmen or clerical workers; 14 were managers, officials, or proprietors; eight were professional or technical workers; one was a housewife; and no report was obtained for five.

Patients reported that the duration of their current or last job varied from one day to 40 years. Sixty-one had worked less than three months for their latest employer; 80 others had worked for periods ranging from three months

AGE DISTRIBUTION OF THE YOUNGEST CHILD OF 197 PATIENTS WITH CHILDREN

Age of Youngest Child	Number of Patients
Under 6 years	37
6 years but less than 12	41
12 years but less than 18	32
18 years and over	78
Unknown age	9
Total	197

TABLE III

AGE DRINKING BEGAN AS REPORTED BY PATIENTS

Age Drinking Began	Number of Patients
Less than 15 years	36
15, but less than 20	129
20, but less than 25	69
25, but less than 30	27
30 and over	27
Unknown	19
Total	307

TABLE IV

to a year; 48 had worked a minimum of one year but less than three years; 41 had been employed between three and ten years; and 27 had held jobs for ten years or more. The duration of last employment had not been recorded for 50 patients.

Termination of employment because of drinking is another indicator of the extent of deterioration of the alcoholic's stability. Among the 307 patients, 191 or nearly two-thirds reported that employment had been terminated because of drinking. Of the remaining 116, 74 said that drinking had not caused them to lose their jobs, and for 42 this information was not available.

Aspects of History of Drinking

The average age when the patients sought help from the Clinic was 46.1 years (median 45.9), with a range from 21 to 77. This range does not deviate greatly from other studies but the mean age is slightly higher than in the Straus and Bacon study, 41.2⁹, and in the study by Wellman and his associates, 42.6.¹⁰ The greatest concentration was found in the age group from 35 to 55, with 70%, or 214 patients, in this grouping. The five-year age period with

the largest number of patients (67) was 45 to 50. Thirty-eight patients came to the Clinic when they were younger than 35, and 55 or 18% were 55 or over.

Among the questions asked about the patient's history of drinking were: When did you start drinking? And when did drinking become a "problem"? Even though the same degree of reliance cannot be placed on all answers because of differences in the interpretation of the terms "drinking" and "a problem," and because the replies were dependent on the individual's memory, the summarized data bring out quite emphatically that drinking usually began between 15 and 20 years of age.

Only two patients mentioned an age of 40 or older when they started drinking, the oldest being 52.

The age at which the patients reported that drinking became "a problem" was less marked in any one five-year age grouping than was the age at which drinking began. The highest incidence was at ages 30 through 34, and the second highest at ages 35 through 39. Approximately 61% of the total group were between 20 and 40 years of age. The average age was 34.6 years (median 34.0).

It was thought important to look at the time span between the beginning of drinking and the patient's recognition of this habit as a problem. The period between initial drinking and recognition of drinking as a problem was less than five years for 46; between five and ten years for 41; ten years but less than 15 for 59; 15 years but less than 20 for 48; and twenty and over for 78. The elapsed time for 35 was unknown. The shortest period reported by any patient was "less than one year," and the longest, 45 years.

Incidence of arrests was extremely high among this patient group: 258 of the 307 studied said they had court records, 40 reported no arrests, and for nine this was unknown. The range in the number of arrests varied from one, reported by 57, to an unverified figure of 107 reported by one.

Signs of severe pathology—amnesia (blackouts), delirium tremens, and hallucinations—were reported by the patient group. "Blackouts" were mentioned by 189 and delirium tremens and/or hallucinations by 137. No "blackouts" were experienced by 100 and no hallucinations or delirium tremens by 155. Eighteen did not answer the question about "blackouts" and for

AGE PROBLEM BEGAN AS REPORTED BY PATIENTS

Age Problem Began	Number of Patients
Less than 20 years	16
20, but less than 25	41
25, but less than 30	44
30, but less than 35	55
35, but less than 40	49
40, but less than 45	30
45, but less than 50	32
50 and over	23
Unknown	17
Total	307

TABLE V

15 the information on hallucinations and delirium tremens was unknown.

The summary of the replies which the patients gave concerning their reasons for the excessive use of alcohol showed that subjective, psychological reasons such as loneliness, discouragement, and "nerves" were mentioned most frequently. There were 118 in this category. "No reason" or "I don't know any reason" was the answer of 69 patients; 39 said they "liked the taste," or "liked the effect"; only 10 mentioned marital difficulties; six attributed it to physical illness; and 57 gave a wide variety of answers such as "influence of others," "unemployment," "indebtedness," and "when unable to buy barbiturates." Some patients gave more than one reason, and no reasons were recorded for 21.

Sources of Referral and Known to Alcoholics Anonymous

Two final points were examined: source of referral to the Clinic and whether or not the patient was known to Alcoholics Anonymous.

Although 160 patients reported that they had previously been known to Alcoholics Anonymous, only 54 said they were referred by this organization. However, AA was mentioned more often than any other source of referral; second in frequency of being mentioned were social agencies (50); followed by 44 who named "a former Clinic patient"; 39 recalled that "a man on the street," "a person in the bar" or "a friend" had suggested it; the police, a probation officer or some one in a court was named by 27; 26 were self-referrals; 22 mentioned relatives; 22, physicians, attorneys, priests and ministers;

19 gave other sources; and for four the source was not reported.

There were 126 who said they had had no contacts with Alcoholics Anonymous, and no information on this question was available for 21.

Discussion

Research on the cause of alcoholism has led some to believe that it is brought about by a nutritional deficiency or a malfunctioning within the body system. Many others, however, hold that it is a manifestation of a basic character disorder. Without minimizing the need for more intensive research on the cause, the results of this study point to the need for additional research and experimentation in order to discover how to help the alcoholic patient once excessive drinking becomes a problem and before these problems become acute. It would appear that there would be a greater chance of rehabilitation if the patient were younger when he applied to the Clinic than the average age of 46 years. At what age is the prognosis for recovery most favorable? What kind of an educational program would induce the alcoholic to seek help at an optimum age for recovery?

It was noted in the study that only a small percentage gave social agencies as the referral source. Was this due to inaccurate recollection and reporting by the alcoholic, or would increased cooperation and a more closely supervised referral plan between the treatment center for alcoholics and other social agencies increase the chances of rehabilitation?

A final point which can be made to support the proposed research is provided by the realization that the severe pathology found among a sizeable group of Clinic patients, and the occupational, family, marital, and community maladjustments are responsible for a socio-economic loss to society which is immeasurable.

Summary

A group of 307 persons who were accepted for the treatment of alcoholism at the Central Indiana Alcoholism Clinic from the inception of the Clinic on July 1, 1957, to March 1, 1959, have been described. With but 27 exceptions, these patients resided in Indianapolis or beyond the city limits but in Marion County. Indiana was the birthplace for 146, 148 were born in other states, two in foreign countries, and for 11 the place of birth was unknown. Only 10 were women; 18 were Negroes.

The average educational attainment was two years of high school with a range from no formal education to two years of graduate education. There were 112 who had an eighth grade education or less; 150 had from one to four years in high school but did not attend college; 41 had some college education but only eight in this group received degrees.

Protestants far outnumbered persons of other religious faiths (238); 61 were Catholics; none was of the Jewish faith; seven reported no religion; and the religion of one was unknown.

Only 66 were married when they came to the Clinic although 269 were known to have been married at least once; 173 were divorced or separated; 38 were single; and 30 were widowed. Multiple marriages were reported by 89.

There were 197 who had children and of this group 111 had either one or two; 74 had three to five; and 12 had six or more. At least one child was younger than 18 years of age in 110 instances, and in 75 families all children were younger than eighteen. The youngest child of 23 patients was under three years; of 55, between three and 12 years; and of 32, 12 years but less than 18. Seventy-eight had no children under 18.

Length of residence at the last address was less than one year for 109; one year up to five years for 65; five to ten years for 28; and 31 had not moved for at least ten years.

Nearly one-half (149) were roomers, or lived in "cheap" hotels, missions, railroad cars or "here and there"; 83 lived in their own homes; 55 were with relatives; and living arrangements were unknown for 20.

Excessive use of alcohol had affected the employment status of a large majority: 237 were unemployed and 191 reported that they had lost their jobs at least once because of drinking. Wide variations occurred in the duration of the patient's latest job (one day to 40 years) but 61 worked less than three months; 80 worked from three months to a year; 48 worked a minimum of one year but less than three years; 41 had been employed three to ten years; and 27 had held jobs for ten years or more. The duration of last employment was not recorded for 50. The usual occupations of 174 were classified in the category of "skilled" and "semi-skilled"; 78 were "unskilled" workers; 14 were managers, officials, or proprietors; only eight were professional or technical workers.

The average age when the patient came to the Clinic was 46.1 years, with a range from 21 to 77; 214 were between 35 and 55; 38 were younger than 35; and 55 were 55 and over.

The most common age for initial drinking was between 15 and 20 years, reported by 129 (median 19.1); 36 said they were younger than 15; 69 were 20 but under 25; 27 were between 25 and 30; and 27 were 30 or over. The age of initial drinking was unknown for 19. The average age for the onset of alcoholism was 34 with 189 reporting that drinking became a problem between 20 and 40 years of age.

The elapsed time between initial drinking and the onset of alcoholism was less than five years for 46; less than ten years for 87; less than 15 years for 146; less than 20 years for 194; 20 years or over for 78; and unknown for 35.

The incidence of arrests was high, with 258 giving a history of having a court record. The number of arrests reported by patients ranged from one to the unverified figure of 107.

There were 189 who reported amnesia (black-outs), and 137 mentioned delirium tremens and/or hallucinations.

In 118 cases, alcoholism was attributed to loneliness, discouragement, "nerves,"—in other words, to subjective, psychological reasons. There were 69 who said there was "no reason" or they did not know of any reason; a smaller group (39) "liked the taste" or "the effect;" 10 mentioned marital difficulties; six gave physical illness as the cause; 57 gave answers classified in a miscellaneous group; and no reasons were recorded for 21.

Although 160 patients reported they had previously been known to Alcoholics Anonymous, 54 said they came to the Clinic through referrals by this organization; 50 named social agencies as the referral source; 44 mentioned former Clinic patients; 39 came because of a suggestion of "a man on the street," "a person in the bar," or "a friend;" 27 came because of legal difficulties; 26 were self-referrals; 22 were referred by professional persons; 19 named other miscellaneous sources; and the source for four was unknown.

Although it is impossible to describe the

"typical" Clinic patient in terms of all characteristics examined, it can be said that he was a white, Protestant, male; had a formal school education of ten grades; had been married at least once but was divorced or separated at the time he came to the Clinic. He had one or two children, and one child was still younger than 18 years. He was no longer living in a family unit but was a "roomer" lacking residential stability. His usual occupation was as a skilled or semi-skilled worker but the excessive use of alcohol had caused him to lose his job one or more times, and he was now unemployed. He was 46.1 years old; initial drinking occurred at 19 years and the onset of alcoholism at 34. He had been arrested, probably for public intoxication. He attributed his excessive use of alcohol to discouragement, loneliness, "nerves,"—in other words, to the need to "escape." He had been known to Alcoholics Anonymous, but he was uncertain whether this organization or some other referral source was responsible for his seeking help from the Clinic.

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New Innovation on Appendectomies

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THE PURPOSE of this article is to introduce a procedure we have adopted recently on appendectomies, and one which we believe has not been previously used. It has proven so simple, practical and successful, that its elementary principle is almost embarrassing to suggest.

After innumerable appendectomies performed over many years, we were still unable to avoid the rather frequent occurrence of bleeding from the vessels of the meso-appendix. Control of this bleeding has always been more or less exasperating, and on occasion a serious problem. After we discussed this problem, we adopted the following variation in technic, which we have now used successfully on several recent appendectomies, with absolutely no bleeding, and uneventful convalescence. We intend to continue its use.

Procedure

We wish to submit the following procedure, with the accompanying diagrams:

After the caecum and appendix have been delivered through whatever type incision has been made, the meso-appendix is perforated near the base of the appendix and a ligature is drawn through this opening, and ligated transversely around the meso-appendix. Then one tip of a

hemostat is placed through the original aperture in the meso-appendix and the appendix is crushed at its base. The hemostat is removed and one end of the suture is drawn through the same original aperture in the meso-appendix, and the ends are ligated around the crushed appendix. Then the ligature is placed around the entire base of both the appendix and the meso-appendix.

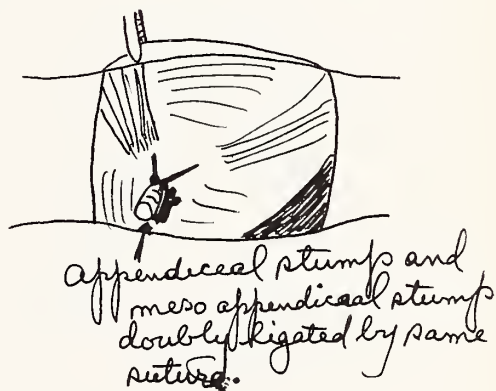
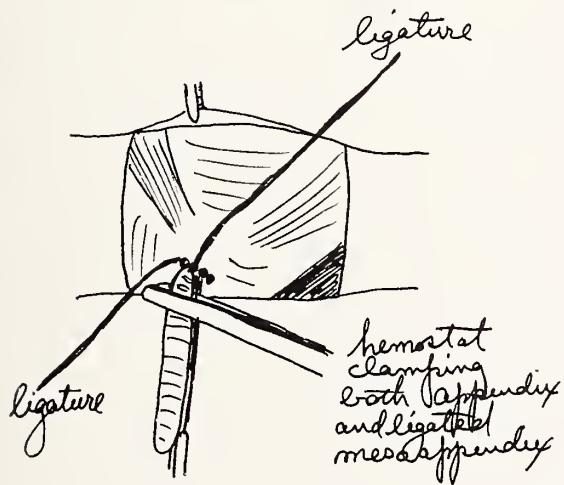
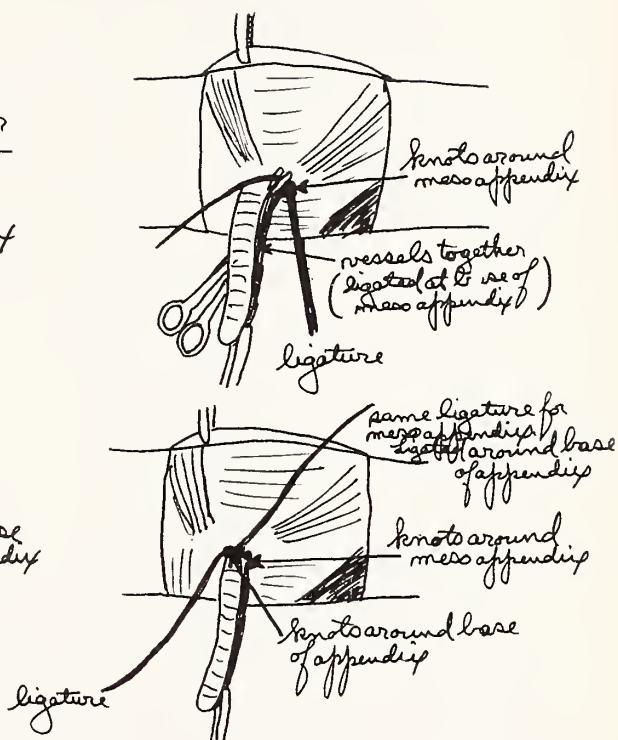
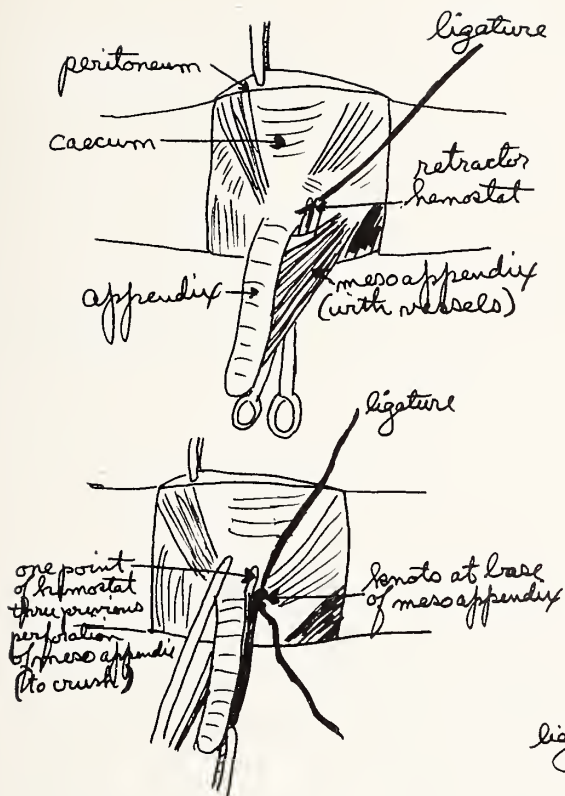
In the above manner no vessels can be omitted in the ligature and no bleeding can occur.

The distal portion of the appendix, together with the meso-appendix, is then crushed with a hemostat, removed with a knife, and the appendiceal stump is carbolyzed.

Advantages

- 1) This procedure eliminates the possibility of bleeding.
- 2) There is even less of the meso-appendix remaining than when it is cut along the length of the appendix.
- 3) There is no worry afterward as to whether a ligature around a vessel may slip off.

Therefore, we feel this simple innovation is so worthwhile that it merits passing along.



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The Case of the

THE FAGGOTS, piled high at the entrance to the synagogue, were blazing furiously. The entire congregation, including nursing babes in arms, was huddled inside; the Sh'ma was being intoned as the flaming rafters fell in. A crazed woman, her tatters and hair aflame, dashed out only to be speared by the Duke's burly, jerkined halberdiers. The town crier had read the proclamation condemning the Jews to a fiery death for the heinous crime of having brought the plague to Worms. The populace howled its relish of the diverting spectacle. Rats were scurrying unnoticed in the heaps of garbage and excrement.

It was Germany and the year was 1271. The Dark Ages of Europe were drawing to a close but the Renaissance was not yet. Louis IX of France (St. Louis to be) had just died in Africa leading the Eighth Crusade. The ephemeral Christian kingdoms in Palestine were being absorbed by the conquering Mongols who embraced not Christianity but Mohammedanism. Young Marco Polo had recently set out on the journeys to the Great Khan which were to make his name immortal. The fact that rats had reached Europe on the returning caravels of the Crusaders did not seem to be an observation worthy of being recorded. Certainly no one then alive could even imagine any connection between them and the "Black Death"—THE Plague which was to ravage Europe repeatedly in the succeeding centuries.

Booted Skull

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Not for many centuries was the true story of bubonic plague infection to be unraveled. Not until 1894 were Kitasato and Yersin to discover that *Pasteurella pestis*, the germ they recovered from the blood of dead victims, was the actual cause of the dread disease. It was Paul Simond who found the bacilli in the alimentary tract of fleas taken from plague rats. When the infected rats sickened and died (for plague is a disease of rodents primarily), their bodies cooled in death. The now starving fleas would abandon their dead victims and swarm to the nearest warm body available: another rodent preferably but a human would do nicely.

There are some 1500 species of rodent fleas; it is *Xenopsylla cheopsis*, the native flea of India, that plays the unwilling role of being the principal host harboring the plague bacillus. Careful observations just within the 20th century have shown that, when this particular flea feasts upon an infected rat, it ingests some 5000 bacilli which then proceed to multiply within the flea's stomach. Modern day parasitologists have come up with the apparently trivial observation that the Indian flea has a defective proventricular valve in the esophagus that plugs easily. However, this is precisely the crucial link connecting human bubonic plague with the rat and its fleas: The flea with the plugged esophagus bites its next victim anyways. Usually, it is another rat; if rats are unavailable, humans may be the unwitting hosts. As the flea's lancet is sunk into a

victim's skin, something like 20,000 plague bacilli are regurgitated into the subcutaneous tissues—and all because of the defective valve! Of course, it is this inoculation that initiates the phlyctenule or blister that is so characteristic of the disease and that gives it its name.

Lost in Today's Texts

Today, even the most standard textbooks of medicine fail to give all this detail. Let us hope that there will be no need for our doctors to brush up on this killer of medieval and quite recent days. It is worth remembering that as recently as 1912 there was a severe epidemic of the almost 100% fatal pulmonary form in Manchuria. Michener in "Hawaii" has a mild description of the flare-up on those islands; Dr. Slaughter has a novel dealing with WHAT WOULD HAPPEN were an outbreak to occur in New York. Let us also not forget that the disease is endemic in the rodents living on the Western slopes of the Rocky Mountains. . . .

Be all this as it may, back in 1271, it was the Jews who were the official scapegoats for the dreadful visitation of the Angel of Death. It was the Jews who were accused of poisoning the wells, greasing doors with poisonous unguents and adding deadly ingredients to the wares they sold. The official pattern being set met with enthusiastic approval; its broad outlines were imitated for centuries to come; screams of the condemned were submerged in the huzzahs of the applauding spectators. Rats scurrying in the garbage piles remained undisturbed. . . .

The centuries went by but the same river was still flowing between the same hills. Now, however, the town was a city. Electric lights were twinkling in the dusk of the evening; motor traffic was fairly heavy. The Old People's Home was a very beautiful, just completed structure well furnished with all the latest.

Radiant, Vivacious Student Nurse

Fraulein Irene Droeger was a vivacious, pert little student nurse at the institution. At 18, she radiated health, youth and a gay, heartwarming charm; her patients adored her. She worked intensely at her exciting vocation. She was proud of her dark, handsome father who was both a worthy surgeon and the spiritual leader of the Jewish community. She adored her Nordic mother who was also the head nurse of the hospital. Her older brothers and a younger sister



completed a harmonious family circle of rare culture, learning and model living.

It was Friday night. The apartment of the Droeger family at the hospital had a festive appearance. Irene's mother had lit the candles and Dr. Droeger had started the evening service. Just as he was reciting the Sh'ma, there was a tumult in the outside corridors. The doors burst open and Streicher's SS troopers streamed in. The small pulpit was knocked over and furnishings were smashed ruthlessly as Irene's father and brothers were butchered obscenely. She herself was cuffed mercilessly and dragged off by the brawling, drunken louts. The dazed girl was raped by a succession of her lustful captors and then tossed aside for more promising sports.

As the unconscious form lay there, a prowling trooper stumbled over the huddled body; the heavy black boot struck the skull squarely; the head gave a soft plop much like the sound of a watermelon splitting open. Only the recording angels took note of the BOOTED SKULL being smashed in; there were no human ears to listen at the cursing Nazi exclaim, "Verflüchte Jüdin" as he recovered his stride and hurried on without another glance at his victim. It was November 1938 in Germany; the Crystal Glass

pogroms of Hitler's inauguration of the preliminaries to his "Final Solution of the Jewish Problem" had begun. . . .

For two days, the broken, inert human remnant lay among the dead and dying. Finally, some nuns had the courage to come and care for those still breathing. Miraculously, Irene survived successive transfers to Switzerland, France and—finally—the United States. Mentally, she was completely out of contact. She was submissive but had to be given the most elementary care. There was no sign of recognition as one would speak to her. She stared mutely without seeing when she was not fast asleep or having epileptic seizures.

In 1948 the Pilgrim State Hospital on Long Island, N. Y. housed her in one of its back wards. Her chart contained the meager information concerning her that had survived repeated transfers. The newly-assigned physician was examining her when he noticed the deeply depressed, healed skull fracture. In pity, he muttered, "Sh'ma Israel!" To his intense amazement, he saw the patient's face change and he heard her say, "Adonoy Eloheinu! Adonoy Echod! "—"Hear, Oh, Israel: The Lord, Our God: The Lord is One:

Resumes Where She Left Off

Irene Droeger had resumed where she had left off TEN YEARS BEFORE. The physician was strangely elated and excited; he had stumbled on the handle opening the door to the girl's frozen intellect: the channels, immobilized with the horror of the terrible night in Nazi Germany, revealed a beckoning chink. . . .

The passive patient was examined now in a really meticulous fashion. X-rays and encephalograms revealed the full extent of the ghastly cerebral damage compounded by a decade of neglect. Still, the neurosurgeon was willing to try; he spent the better part of a day in removing the spicules of bone tugging so cruelly at the underlying neopallium; carefully and tenderly, he snipped away at the radiating scars; meticulously and skillfully, he refashioned the bony cover over the reconstructed dura: everything that modern surgery had to offer was done. And then, the medical team took over—the psychiatrist, the physiotherapist, the nurses and the specialized teachers. Irene Droeger was started on intensive psychological retraining. It was found that the entire Hebrew ritual would be followed by her as old reflexes and cerebral pathways were probed. Then, lessons in English, orientation, just conversation—other things.

Slowly but steadily, the inhibited reflex pathways were reestablished; new patterns were inculcated. A rabbi helped immensely. He was patient and kind; also, he had a physique and a voice reminiscent to Irene of her father. The girl was moved to an open ward; she began to attend classes in rehabilitation. Then she was permitted to go out to Friday night services in a regular congregation. Within another year, it was possible for her to go to night high school classes!

Discharged on Parole

In 1954, she was discharged from the hospital on parole and was placed in a job as a packer in a pharmaceutical firm. She obtained a small room at the Young Women's Hebrew Association; she established friendships with some fellow employees. In 1958, Irene Droeger was 38 years old. Her physical condition was quite good. There had been a complete cessation of the epileptic seizures. There were no organic ailments. The electroencephalogram showed marked improvement and was considered as being within normal limits. She had no emotional conflicts seeming completely reconciled with her station in life. Her deeply ingrained religiosity was an important factor in her reconciliation with the cruel events shattering her life.



At the synagogue services memorializing that infamous Crystal night, I had the privilege of sitting in the same pew with her. Afterwards, she told me that she had received word about restitution from Germany. Rather shyly, she asked me whether I thought that she could stand a trip to Worms and a search for graves, if any, of her kin? There was no rancor in her towards the wretches who had wrought so grievous an injury to her and hers. Her faith and prayers formed a shield protecting her from the buffeting rigors of life.

My faith was not of such invincible quality—I rather equivocated. And then I stopped by to see her on the following Friday evening. She had her table set; two of her friends were with

her. I watched her as she said the motzi; we talked awhile over the Shabos meal. The serenity of her spirit and the clarity of her thinking amazed me. I permitted her to go.

She went and she came back; she is still a valued worker at the pharmaceutical firm. She tells me that she plans to resume a nursing career; As I go about my rounds and encounter some particularly rough problem, I pause and think back to my patient with the BOOTED SKULL; I confess that the thought of this woman gives me renewed faith and courage:

The Lord Watches; All Is Well! ◀

1270 Fifth Ave.,
New York

The Good Society

The good society is surely one in which people are allowed to keep enough of what they earn so that they can pay for their homes, medical aid, and other needs without government assistance. And it is foolish to say that such a society is visionary; fifty years ago it existed in these United States. But it is receding farther and farther into the distance and it is part of the corrupting effect of the Welfare State that resistance to it tends to weaken as the individual is able to keep less and less of what he earns because of its exactions.

William Henry Chamberlain: *The Freeman*, Vol. 11, August, 1961;
Reprinted in *Northwestern Medicine*, Sept., 1961

LABORATORY

MEDICINE

Published periodically as a review of clinical laboratory procedures suitable for laboratories with minimal equipment.

Specific Gravity of Whole Blood and Plasma

A. WENDELL MUSSER, M.D.*

MANY METHODS of analysis in the clinical laboratory have come and gone with the times. Others are with us now and some have been and will be lost in the mountain of medical literature. A few of these older methods can be of use to practicing physicians who have little or no equipment and relatively untrained help.

The specific gravities of body fluids, such as whole blood, plasma, and serum may be determined by delivering drops of blood or plasma from syringe needle, medicine dropper, or glass capillary into a series of copper sulfate solutions of known specific gravity. Each drop, on entering the solution, becomes encased in an envelope of precipitated copper proteinate, and remains as a discrete drop without change of gravity for 15 to 20 seconds, during which its rise or fall reveals its gravity relative to that of the solution. From these gravities, hemoglobin, hematocrit, and plasma (or serum) total protein may be calculated from relatively simple calculations.

Methods

Draw 5 ml of blood by clean venipuncture and place in a sedimentation rate bottle. Mix well, but avoid violent shaking. Do not apply the tourniquet for more than one minute while

drawing the blood. Centrifuge a portion of the specimen to obtain clear plasma. (Caution: mix specimen well before dividing.) Deliver a drop of plasma, serum or whole blood from a height of about 1 cm above the chosen copper sulfate standard from a medicine dropper or syringe needle. Small drops should be used because they permit more tests before a standard must be changed. (Caution: Mix whole blood specimen by at least 10 inversions before using it in the test.)

Observe the behavior of the drop in the solution. If the drop is lighter than the solution, it will rise, perhaps only a few millimeters and may then sink again. If the drop is heavier, it will continue to fall. If it is of the same specific gravity, it will remain stationary for 10 to 15 seconds and then fall. The action of the drop during the 10 seconds after it has lost its momentum determines whether it is lighter or heavier than, or the same as, the test solution.

Calculations

Whole blood gravities (Gb) and plasma gravities (Gp) as determined are used to calculate plasma proteins, hemoglobin and hematocrit by use of the equations given below. If the oxalate mixture (in sedimentation rate bottle) is used, subtract 0.0004 from the observed gravities for each mg. of oxalate mixture per ml. of blood (i.e. subtract 0.0008 from the observed gravities since each ml. of blood in the sedimentation rate bottle contains 2 mg. of oxalate mixture). If heparin is used for the anticoagulant, no cor-

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rection is necessary. If serum is used instead of plasma, add 0.0005 to the observed gravity to obtain the plasma gravity.

Gp indicates specific gravity of plasma (water being taken as unity at the same temperature); Gb indicates gravity of whole blood; 1.0970 is the mean specific gravity of the cells; 46.1 is the mean O₂ capacity of cells, 33.9 the mean gm. of hemoglobin per 100 ml. of cells.

Plasma proteins (gm per 100 ml. of blood)
 $=370(\text{GP}-1.0070)$

Hematocrit (ml. of cells in 100 ml. blood)
 $=100(\text{Gb}-\text{Gp})$
 $\frac{1.0970-\text{Gp}}$

Oxygen capacity (ml. O₂ bound by 100 ml. of blood)
 $=46.1(\text{Gb}-\text{Gp})$
 $\frac{1.0970-\text{Gp}}$

Hemoglobin (grams per 100 ml. of blood)
 $=33.9(\text{Gb}-\text{Gp})$
 $\frac{1.0970-\text{Gp}}$

Reagents

1. Oxalate mixture (Heller & Paul): Dissolve 8 gm of potassium oxalate and 12 gm of ammonium oxalate in distilled water. Dilute to 1000 ml with distilled water. Place 0.5 ml of this mixture in clear bottles and dry in an incubator at 38° C or in an oven under 80° C and then stopper. Heparin (0.2 mg per ml of blood) may also be used as an anticoagulant.

2. Copper sulfate, saturated solution: Place four pounds of crystalline copper sulfate (Cu SO₄.5HOH) in a four liter bottle. The copper sulfate should be pulverized or fine enough to pass through a #20 mesh. Add 2500 ml of distilled water. Stopper the bottle and shake vigorously. Take the temperature of the supernatant solution, to the nearest half degree Centigrade immediately at the end of the shaking period. Decant the supernatant immediately through a large funnel with a cotton piling filter into a clean, dry four liter bottle. This saturated solution is at once diluted to make a stock solution of specific gravity of 1.100 according to the directions in #3 below.

3. Stock copper sulfate solution, 1.100 gravity: Immediately after saturation, dilute the saturated copper sulfate solution as indicated in Table I. Measure the volume required in a 500 ml cylinder and pour it into a liter volumetric flask. Drain the cylinder for 30 seconds. Fill the

flask to the mark with distilled water and mix. After standing for a minute or two, add enough water to bring the volume back to the mark. Mix again and pour the solution into a clean four liter bottle. Use the same flask to prepare three more liters of solution, rinsing the flask each time and discarding the rinsing. The saturated solution, the stock solution, and the standard solutions described below should all be prepared at within 5° C of the same temperature. Once prepared, the standards may be used at any temperature within $\pm 15^\circ$ C of that at which prepared.

4. Standard copper sulfate solutions (100 ml. portions): Using a buret filled with stock solution, specific gravity 1.100, run into a 100 ml volumetric flask the amount indicated in Table II. Dilute then to the mark with distilled water, mix and transfer to a 4 ounce "oval prescription bottle." Stopper at once. Rinse the flask, discarding the rinsings and prepare the next standard. Continue until the entire set from specific gravity 1.008 to 1.075 is prepared. The 100 ml standards serve for about 100 tests. Partial sets may be prepared.

ML. of SATURATED COPPER SULFATE SOLUTION TO BE DILUTED TO 1 LITER TO GIVE A STOCK SOLUTION OF SPECIFIC GRAVITY 1.100

Temperature °C.	cc.	Temperature °C.	cc.	Temperature °C.	cc.
10.0	578				
10.5	573	20.5	484	30.5	423
11.0	568	21.0	480	31.0	420
11.5	563	21.5	477	31.5	417
12.0	558	22.0	473	32.0	414
12.5	553	22.5	469	32.5	412
13.0	548	23.0	466	33.0	409
13.5	543	23.5	463	33.5	406
14.0	539	24.0	460	34.0	403
14.5	534	24.5	456	34.5	401
15.0	529	25.0	453	35.0	398
15.5	525	25.5	450	35.5	395
16.0	521	26.0	447	36.0	392
16.5	516	26.5	445	36.5	390
17.0	512	27.0	442	37.0	387
17.5	508	27.5	439	37.5	384
18.0	504	28.0	436	38.0	381
18.5	500	28.5	434	38.5	379
19.0	496	29.0	431	39.0	376
19.5	492	29.5	428	39.5	373
20.0	488	30.0	425	40.0	370

Temperature in °C refers to the temperature of the saturated solution at the time of saturation (end of shaking for 5 minutes).

TABLE I

ML. OF STOCK COPPER SULFATE SOLUTION OF GRAVITY 1.1000 TO BE DILUTED TO 100 ML., 50 ML. or 25 ML. TO PREPARE STANDARD SOLUTIONS OF GRAVITY, G, TO WITHIN \pm 0.001

G	100	50	25	G	100	50	25
1.008	7.33	3.67	1.84	40	39.00	19.50	9.75
9	8.32	4.16	2.08	41	40.00	20.00	10.00
10	9.31	4.66	2.33	42	41.00	20.50	10.25
				43	42.00	21.00	10.50
11	10.30	5.15	2.58	44	43.00	21.50	10.75
12	11.29	5.65	2.83	45	44.00	22.00	11.00
13	12.28	6.14	3.07				
14	13.27	6.64	3.32	46	45.00	22.50	11.25
15	14.26	7.13	3.57	47	46.00	23.00	11.50
				48	47.00	23.50	11.75
16	15.25	7.63	3.82	49	48.00	24.00	12.00
17	16.24	8.12	4.06	50	49.00	24.50	12.25
18	17.23	8.62	4.31	51	50.00	25.00	12.50
19	18.22	9.11	4.56	52	51.00	25.50	12.75
20	19.21	9.61	4.81	53	52.00	26.00	13.00
				54	53.00	26.50	13.25
21	20.20	10.10	5.05	55	54.00	27.00	13.50
22	21.19	10.60	5.30				
23	22.17	11.09	5.56	56	55.00	27.50	13.75
24	23.15	11.58	5.79	57	56.00	28.00	14.00
25	24.14	12.07	6.04	58	57.00	28.50	14.25
				59	58.00	29.00	14.50
26	25.12	12.55	6.28	60	59.00	29.50	14.75
27	26.10	13.05	6.53	61	60.00	30.00	15.00
28	27.08	13.54	6.77	62	61.00	30.50	15.25
29	28.06	14.03	7.02	63	62.00	31.00	15.50
30	29.04	14.52	7.26	64	63.00	31.50	15.75
				65	64.00	32.00	16.00
31	30.00	15.01	7.51	66	65.00	32.50	16.25
32	31.00	15.50	7.75	67	66.00	33.00	16.50
33	32.00	16.00	8.00	68	67.00	33.52	16.76
34	33.00	16.50	8.25	69	68.10	34.05	17.02
35	34.00	17.00	8.50	70	69.10	34.56	17.28
				71	70.20	35.08	17.54
36	35.00	17.50	8.75	72	71.20	35.60	17.80
37	36.00	18.00	9.00	73	72.20	36.02	18.06
38	37.00	18.50	9.25	74	73.30	36.64	18.32
39	38.00	19.00	9.50	75	74.30	37.15	18.58

G = Specific gravity of standard solution. 50 = ml. of 1.100 stock solution diluted to 50 ml.
 100 = ml. of 1.100 stock solution diluted to 100 ml. 25 = ml. of 1.100 stock solution diluted to 25 ml.

TABLE II

Accuracy of Method

The plasma proteins calculated from specific gravities are within \pm 0.4 gm. of proteins calculated from accurate macro-kjeldahl analyses. When the blood area is very high (over 100 mg per 100 ml), the gravity-calculated proteins are likely to be somewhat too high, because the non-protein constituents contribute more to the gravity than is allowed in the calculations. Shock and allied conditions in man do not seem to affect seriously the accuracy.

In normal blood, and in pathological bloods, in which the hemoglobin concentration within the red cells is not affected, the hemoglobin content has been found regularly within 2% of the value measured by oxygen capacity. The error can be larger in pernicious anemia; however, relatively little error is involved because changes in the hemoglobin content of the cells change the cell specific gravity in the same direction.

The percentage of error in calculation of hematocrits from specific gravities is greater

than in calculation of hemoglobin. Hematocrit results are useful unless the abnormality of hemoglobin concentration in the cells is great.

Although the above procedure is somewhat complicated, it could be used as a screening aid in an area where adequate laboratory facilities are not available. We must emphasize, however, that there is no substitute for an efficiently and well-supervised laboratory determination.

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Fracture Danger in Karate

The study of Karate, a system of self-defense relying on the effective use of arm and body, should be undertaken only with a skilled, reputable instructor, according to a consultant for the JAMA.

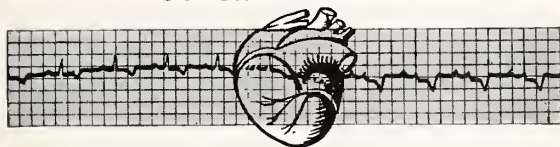
"The danger of fracture of a finger or metacarpal (hand) bone, whether occurring in a misdirected swipe of the hand or by overly enthusiastic pounding, is a real one," Dr. Alexius Rachun wrote in a recent issue of the Journal.

In order to achieve proficiency in Karate, it is necessary for the student to devote several years to a study which involves not only practice in the execution of skillful striking maneuvers of the hands and feet and other parts of the body, but, in addition the striking edges and surfaces of these parts must be toughened and enlarged by repeatedly hitting them against progressively harder objects.

It is important to recognize that the hands and feet of a Karate expert are dangerous weapons, and, for this reason, only responsible, emotionally stable students should undertake the study. . . .

Virginia Medical Monthly, Sept., 1961

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Supraventricular Impulses With Aberrant Intraventricular Conduction

*CHARLES FISCH, M.D.**

Indianapolis

THE DIFFERENTIATION of (1) aberrant ventricular complexes originating in the ventricles from (2) supraventricular beats with aberrant intraventricular conduction is of primary importance in the diagnosis of ventricular tachycardia. However, under certain conditions aberrant conduction of sinus beats, when coupled with ventricular ectopic beats, may simulate multifocal ventricular beats. The latter diagnosis usually carries a prognosis which is much more serious than that suggested by ordinary isolated ventricular ectopic systoles. An example of aberrant conduction of sinus beats simulating multifocal ventricular prematures is illustrated in Figure 1.

In lead II three types of ventricular complexes are seen and are represented by the first three beats. The first complex is preceded by a P wave and represents a normal sinus impulse. The next complex is a ventricular premature systole and this complex is followed by another

aberrant intraventricular QRS which differs from the second beat both in shape and duration thus superficially suggesting multifocal ventricular premature beats. The same sequence of events is recorded in lead AVF.

The clue to the proper diagnosis is suggested by V-I. Here the ventricular premature beat appears to be interpolated with a minimal aberrancy of the complex which follows the ventricular ectopic but with an initial small R wave identical to those of the normally conducted beats, indicating supraventricular origin of the complex.

With evidence at hand of existence of interpolated ventricular premature systoles an interpretation of leads II and AVF is as follows: the first complex in lead II (second in AVF) is a normally conducted S-A beat followed by ventricular premature which is interpolated in character. A P wave (P-P interval .88 sec) is buried in the T of the premature systole and is followed by a P-R of .22-.24 sec. which conducts normally, but falling in relative refractory period of the ventricular conduction system, gives rise to an aberrant third beat in lead II (fourth in AVF).

*From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association, Indiana State Board of Health and the National Heart Institute (H.T.S. 5363).

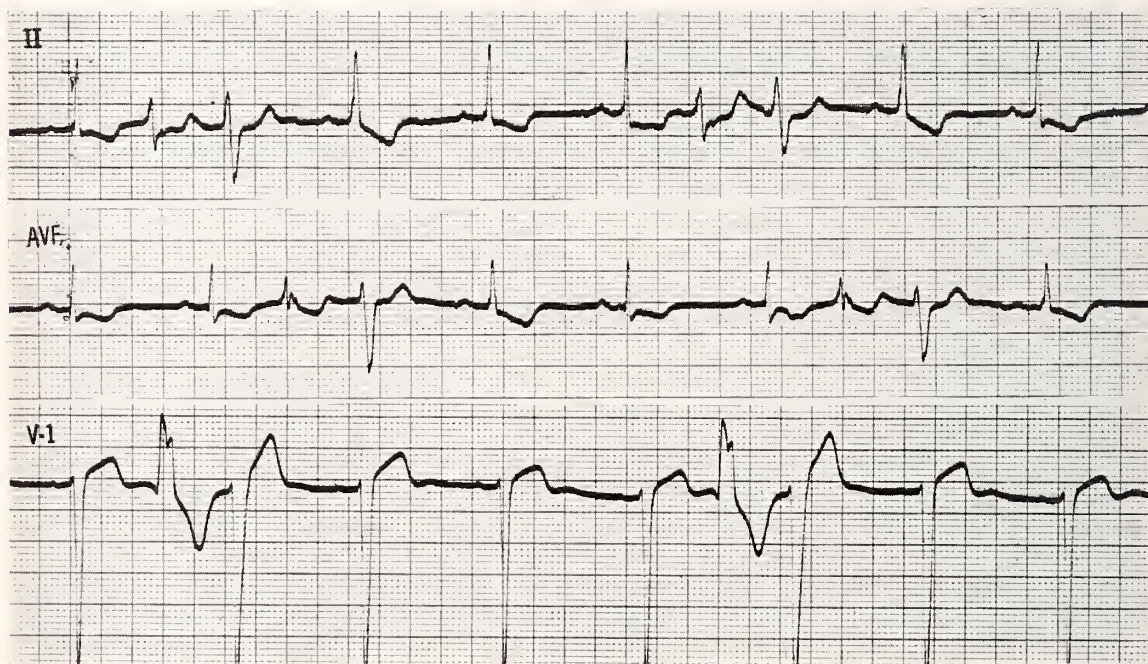


FIGURE 1

THIS SHOWS aberrant conduction of S-A beat suggesting multifocal ventricular premature systoles. For details see text.

A Convention First...

FIRESIDE CONFERENCES

Tuesday, October 24, 8:00 p.m., Columbia Club

This feature is being introduced to the annual convention by the Indiana State Medical Association and the Indiana Chapter of the American College of Chest Physicians for all physicians. These conferences consist of informal discussions with your colleagues, including nationally and locally-known physicians interested in the subject. Ten major topics are presented and the physician may visit from one table to another asking questions, or commenting on various problems of the subject at hand. You are invited to bring x-ray films and electrocardiograms to obtain the opinion of the discussors present. This promises to be a most informative and enjoyable evening.

Honored Guest Participants

HOLLIS E. JOHNSON, M.D., Professor of Clinical Medicine, Vanderbilt University, Nashville, Tenn., President of the American College of Chest Physicians.

JOHN F. BRIGGS, M.D., Associate Professor of Clinical Medicine, University of Minnesota, St. Paul, President-Elect, American College of Chest Physicians.

HERMAN J. MOERSCH, M.D., Emeritus Professor of Medicine, Mayo Foundation, University of Minnesota, Rochester, Past President and Director of Education & Research of the American College of Chest Physicians.

ANDREW L. BANYAI, M.D., Emeritus Clinical Professor of Medicine, Marquette University of Milwaukee, Chicago, Past President and Director of Foreign Affairs of the American College of Chest Physicians.

LEON UNGER, M.D., Associate Professor of Medicine, Northwestern University, Chicago.

EDWIN R. LEVINE, M.D., Assistant Professor of Clinical Medicine, Chicago Medical School, Chicago.

PROGRAM

1. *Emphysema and Unusual Pulmonary Diseases*

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LEON UNGER, M.D., Chicago

EDWIN R. LEVINE, M.D., Chicago

ROY H. BEHNKE, M.D., Indianapolis

WALTER CHRONIAK, M.D., Indianapolis

2. *Pulmonary Tuberculosis and Fungous Diseases*

Moderator of Tuberculosis: HOLLIS E. JOHNSON, M.D., Nashville, Tennessee

Moderator of Fungus Diseases: ARVINE G. POPPLEWELL, M.D., Indianapolis

EDWARD W. CUSTER, M.D., South Bend

PHILLIP H. BECKER, M.D., Crown Point

JACOB K. BERMAN, M.D., Indianapolis

RUSSELL S. HENRY, M.D., Indianapolis

3. *Industrial Diseases of the Lung*

Moderator: DONALD W. BRODIE, M.D., Indianapolis

LOUIS W. SPOLYAR, M.D., Indianapolis

HAROLD C. OCHSNER, M.D., Indianapolis

WARREN S. TUCKER, M.D., Indianapolis

GLEN A. RAMSDELL, M.D., Richmond

4. *Trauma of the Thorax*

Moderator: EDWIN R. EATON, M.D., Indianapolis

GEORGE BUCKNER, M.D., Ft. Wayne

JOSEPH C. FINNERAN, M.D., Indianapolis

DONALD F. MACLEOD, M.D., West Lafayette

ROLAND B. RUST, JR., M.D., Indianapolis

5. *Intrathoracic Tumors*

Moderator: HERMAN J. MOERSCH, M.D., Rochester, Minnesota

JAMES C. KATTERJOHN, M.D., Indianapolis

J. STANLEY BATTERSBY, M.D., Indianapolis

JOHN D. MILLER, M.D., Indianapolis

JAMES G. ARMSTRONG, M.D., Indianapolis

6. *Major Arterial Disease*

Moderator: JOHN V. THOMPSON, M.D., Indianapolis

ERICH K. LANG, M.D., Indianapolis

KENNETH R. WOOLLING, M.D., Indianapolis

MYRON H. NOURSE, M.D., Indianapolis

C. BASIL FAUSSET, M.D., Indianapolis

7. *Congenital Heart Disease*

Moderator: JOHN F. BRIGGS, M.D., St. Paul, Minnesota

PAUL R. LURIE, M.D., Indianapolis

J. HAL DORAN, M.D., Indianapolis

WARREN E. COGGESHALL, M.D., Indianapolis

LAWRENCE KINGSLEY, M.D., Indianapolis

8. *Cardiac Arrhythmias and Decompensation*

Moderator: JAMES O. RITCHEY, M.D., Indianapolis

MAX M. EARL, M.D., Kokomo

WILLIAM W. KRIEBLE, M.D., Terre Haute

HAROLD F. BURDETTE, M.D., Indianapolis

CHARLES FISCH, M.D., Indianapolis

9. *Coronary Disease*

Moderator: A. DUDLEY DENNISON, JR., M.D., Indianapolis

FRANCIS W. HARE, M.D., Madison

STUART R. COMBS, M.D., Terre Haute

ARTHUR H. GRIEPE, M.D., Evansville

JACK H. HALL, M.D., Indianapolis

10. *Rheumatic Heart Disease*

Moderator: GEORGE S. BOND, M.D., Indianapolis

MORRIS E. THOMAS, M.D., Indianapolis

DAN L. URSCHER, M.D., Mentone

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Diabetes Detection Week

THE AMERICAN Diabetes Association and its affiliates in conjunction with medical societies and other public-spirited organizations, will observe the week of Nov. 12 to 18 this year as Diabetes Week. The occasion is the renewal of a commendable enterprise which has been undertaken at about this time of year for many years—the Association's Diabetes Detection Drive.

During each year of its existence the detection campaign has been more successful in reaching the general public. Physicians, lay members of the various diabetes associations, labor leaders, business and industrial men, teachers and pharmacists, as well as members of service clubs have in the past and will again this year cooperate to disseminate the knowledge and materials necessary to test as many persons as possible for glycosuria.

Those who show a positive test are offered a free blood sugar analysis. All reports are sent to the testee and to the physician designated by the testee. Last year the Indianapolis Diabetes Association found that 1% of the tests performed lead to the diagnosis of diabetes in a person previously not aware of the disease.

Diabetes mellitus is a surprisingly common disease in the United States. There are more than one million known cases of diabetes today and it is estimated that there are as many or more people who have the disease but do not know it. Since diabetes is a condition which is much more benign when treated early, every effort should be made to provide early diagnosis and early treatment.

Approximately 72,000 persons become diabetic each year. Over five million Americans now living are destined to become diabetic during their lifetime. Until annual physical examinations are almost universal it is prudent to observe annual diabetic detection weeks and months, and to encourage everyone to search for the undiagnosed patient.

The hereditary nature of diabetes makes the checking of the relatives of known diabetic patients especially rewarding. It is thought that there are about 45 million persons in this country, one out of every four persons, who are "carriers" of the disease; that is, they are capable of transmitting the tendency without actually having the disease.

Aside from the hereditary factor there are other characteristics of diabetes. Those who are overweight, and those who are over 40 years of age, and especially in the case of women, are found to be more likely to have the disease.

No age bracket or type of individual, however, is immune and the detection drive should be directed toward the entire population, with the special inclusion of school children.

ISH, MF and HCP

THE LATEST REPORT on sufficiency of hospital facilities in Indiana carries a statistic which will have a sobering effect on everyone who is concerned with this important matter.

Following the publication of the 1961 revision of the Indiana State Hospital, Medical Facilities and Health Center Plan, Dr. A. C. Offutt, State Health Commissioner has announced that "Indiana's hospital program is doing little more than keeping pace with the current population growth."

Dr. Offutt emphasizes that the state needs approximately 4,000 additional general hospital beds and should replace more than 2,300 general beds which now exist in unsuitable facilities.

The total of new beds needed, including those which should be replaced, accounts for the sobering effect of the report. In addition to the 6,300 general beds, there are now needed 990 beds for chronic disease, 3,230 nursing home beds, 5,576 mental and 248 tuberculosis beds. This new estimate is based on the increased population and also on the increased use of hospitals.

The ISH, MF and HCP is revised each year by the staff of the Indiana State Board of Health. It is based on an up-to-date survey of

all hospital, nursing home and medical center facilities for diagnosis, treatment and rehabilitation. It is a device to not only elaborate the overall needs of the state but also to determine the areas which are most deserving of immediate aid. The federal grant-in-aid funds are allocated in accordance with the priorities developed by the Plan.

One example of the forward-looking characteristic of the Plan is its report on rehabilitation facilities. There are a number of private agencies and hospitals providing partial rehabilitative functions, but the report lists only six facilities in the state as providing or developing a comprehensive rehabilitation program. The 1961 Plan recommends that we have six more.

To illustrate what the increased usage of hospitals is doing to the hospital supply mention should be made that the U. S. Public Health Service, for a long time, has reckoned that we should have 7.5 beds per 1,000 population. The national goal will probably be 9.5 beds per 1,000 by 1970.

In the meantime Indiana has a job of getting up to the 7.5 level. Anyone interested may obtain a copy of the 1961 revision of the Plan by writing the Board of Health at 1330 W. Michigan St., Indianapolis.

One Year Old—But Growing Fast!

HOPE, so Webster says, is "desire accompanied by expectation" or "confidence in a future event."

Those definitions, to a large measure, tell the story of I-HOPE — the Indiana Health Organization for Political Education which arose from the desire of Indiana physicians to do something "above and beyond" in the battle against encroachment of the government in the practice of medicine—and the constant threat to the free enterprise system. . . .

These dedicated doctors of medicine, sounding

out sentiment at the "grass roots," have confidence in a future event—namely, that I-HOPE will provide a successful vehicle for political education and for the support of candidates wholly dedicated to the American system of free enterprise.

I-HOPE, as organizations go, is a "stripling" and only recently celebrated its first birthday—but look at the record in that year.

1. More than \$25,000 was subscribed in a voluntary program and the funds have been used in legislative activities and in the successful

support of several candidates whose programs and policies—both at state and national levels—are geared to the true principles of Americanism.

2. I-HOPE, non-partisan in its activity, has made its influence felt among leaders of both political parties who have come to recognize it as an instrument of unusual influence.

3. Several public meetings have been held under I-HOPE sponsorship, featuring nationally known speakers including Dr. Edward R. Annis, of Florida, whose television debates with Walter Reuther and Senator Hubert Humphrey were "high water marks" in support of the continuance of private practice of medicine.

4. It reviewed and forcefully made known the views of medicine on many items of legislation at all governmental levels.

5. I-HOPE has conducted campaigns of political education through various mediums in many sections of the state and will expand its important activity in this particular area.

I-HOPE is not in any way connected with the Indiana State Medical Association; membership consists of many licensed physicians. It is not a temporary organization but has been formulated for permanent service to Indiana doctors, encompassing the whole, broad realm of political and legislative activities.

The coming months will provide I-HOPE with new challenges and new activity as it "re-tools" and prepares itself for additional programs and tasks associated with constantly growing activity in the field of political education and legislative operation.

The need for support will never be greater because, in the foreseeable future, there is no likelihood of any decrease in the attacks on the private practice of medicine and the American free enterprise system.

Information concerning I-HOPE and its program may be made by contacting any of the following physicians who currently compose the committee guiding the organization's activity:

KENNETH L. OLSON, M.D., South Bend,
Chairman

P. J. V. CORCORAN, M.D., Evansville,
Vice-Chairman

DONALD E. WOOD, M.D., Indianapolis,
Secretary

JOSEPH M. BLACK, M.D., Seymour,
Treasurer

E. S. JONES, M. D., Hammond

JACOB PRUITT, M.D., Gary

F. S. CROCKETT, M.D., West Lafayette

RALPH C. EADES, M.D., Valparaiso

G. O. LARSON, M.D., LaPorte

EUGENE F. SENSENY, M.D., Fort Wayne

TRUMAN E. CAYLOR, M.D., Bluffton

RICHARD P. GOOD, M.D., Kokomo

BASIL M. MERRELL, M.D., Rockville

J. G. S. WEBER, M.D., Terre Haute

PHILIP T. HOLLAND, M.D., Bloomington

EDWARD T. EDWARDS, M.D., Vincennes

BILL E. FREELAND, M.D., Batesville

FRANK H. GREEN, M. D., Rushville

CHARLES R. ALVEY, M.D., Muncie

RUSSELL J. SPIVEY, M.D., Indianapolis

Editorial Notes . . .

The American College of Obstetricians and Gynecologists recently held a national conference on maternal mortality. Members of state and local maternal mortality committees met with the college's national committee to discuss ways and means of further lowering an already dramatically-lowered maternal mortality. The careful analysis of maternal deaths by such committees is credited with the lowering of maternal and perinatal mortality from the 1915 rate of 75 deaths per 10,000 live babies to the 1958 rate of fewer than four deaths per 10,000.

Improvement in mortality figures has naturally slowed as the zero point is approached. More work than has already been expended will be required to improve the current experience.

The baby boom is on, says the Health Insurance Institute. We are just now finishing the trimester of months that is the most productive. August, September and October are almost always the busiest. February, April, May and June are the slowest. The monthly variation is so constant that annual variations can be

predicted with accuracy in July, 1961, on this basis, is going to be 3% ahead of 1960. The U. S. is well over 4,000,000 births each year. Such a fertility rate means that one out of every eight women of the proper age bracket are delivered each year. The Insurance Institute advises everyone to get the name of the little one enrolled on the family insurance policy as soon as possible.

The Food and Drug Administration has instituted seizures of vitamin preparations which contain more than 0.4 mg of folic acid per daily dose. One year ago such preparations were placed on the "sold only upon prescription" list. Most manufacturers had withdrawn the more than 0.4 mg tablets from the over-the-counter market; those who did not have been dealt with by seizure. The point involved is a good one. More than 0.4 mg of folic acid per day will mask the peripheral blood symptoms of pernicious anemia but will allow the spinal cord effects to proceed to their ultimate termination.

Seventy-five percent of farm accidents occur after three o'clock in the afternoon, at least in a series of 105 injuries studied by faculty members of the University of Wisconsin and reported in Archives of Environmental Health. Fatigue must be an important contributing cause. 25 percent of the injured individuals said they were in a hurry at the time. In 20% of the accidents involving machines the safety device would have prevented injury if it had been used—all of which prompts the authors to recommend that short rest periods during the day would make farmers' work safer and possibly more productive.

Health insurance continues to grow, and not slowly either. In 1960 4.1 million persons were added to the number covered by one or another type of health insurance, bringing the total coverage up to 131,962,000, 73% of the civilian population. Benefits were up 10% over 1959 to a total of \$5,688,000,000. Major medical made the largest gain with an increase of coverage amounting to 25.6% in the one year.

Elderly people have all sorts of opportunities for health insurance and they don't need to acquire the insurance before they

pass the magic age of 65. There are now at least 118 forms of guaranteed-for-life health policies available. Many of the policies may be purchased after 65 regardless of physical condition. Individuals have a choice of plans even when they are buying them at age 80 or higher. Some group plans accept people 100 years old or more. Different types include hospitalization, medical, surgical and major medical. One of the newer policies is sold at a younger age and becomes paid up at age 65. Lists of plans and policies may be obtained by writing Health Insurance Institute, 488 Madison Ave., New York 22.

Hospitals are saving money in daily costs by dividing the care into minimal, medium and maximum. This allows minimal and medium equipment and personnel in some areas, and concentrates the patients who need maximum care in a highly equipped and specially-staffed area. The North Carolina Baptist Hospital of Winston-Salem found another saving when they converted a former student nurses' residence into a minimal care unit. Remodeling got them 80 beds at a cost of \$10,000 per bed. This freed 80 beds in the main hospital for medium and maximum care. New construction and equipment for standard and maximum hospital care costs at least \$20,000 per bed. Besides, the daily charge in the minimal care unit is from \$7 to \$12. The least expensive ward bed in the hospital is \$13.50. The big difference in cost is in employee ratio. The Baptist main hospital has 2.71 employees per patient, their minimal care setup has one employee for every three patients.

Representative Donald Bruce of the 11th District, in a recent newsletter, neatly and significantly classified welfare statism when he reported on his analysis of his unusually heavy mail from the citizens—95% pro-Freedom and 5% pro-Welfare State.

Despite spotty, partial and sometimes half-hearted use of polio vaccine, the millions of doses that have been given are having the desired effect. Up to August in 1961 the occurrence of polio has been at a record low. Records go back to 1912; no year since then has seen anything close to the phenomenally low incidence of 1961. The U. S. Public Health Service, up to August 5, had received only 363

reports of clinical polio. Pre-school children are the group with the highest incidence. One characteristic of polio in recent years is its tendency to strike pre-school children and young adults in the 20-30 age bracket. Hence the "Babies and Breadwinners" slogan for immunization campaigns.

Special quotation from Khrushchev contained in Congressman Roudebush's weekly newsletter: "We cannot expect Americans to jump from capitalism to communism, but we can assist their elected leaders in giving Americans small doses of socialism until they suddenly awake to find they have communism." Anybody for more social security???

Longevity in the United States gets a little longer each year. At least this is so for the Industrial policyholders of the Metropolitan Life Insurance Company. The average length of life of this considerable sized section of the population was 70.5 years in 1960. This is only slightly higher than the figure for 1959, but it is higher and it is also the highest ever attained. Increases in longevity are small when considered year by year but have gradually added up to quite a spell. The average length of life is now one-half a year longer than it was in 1955, but it is five years ahead of 1946, 10 years ahead of 1937 and 24 years ahead of 1909. American wage-earners and their families have increased their life span more rapidly than has the population in general.

1,945 physicians were the recipients of partial physical examinations at the recent New York meeting of the AMA. Electrocardiograms revealed heart abnormalities in 17.7%. Chest x-rays showed abnormalities in about 25% of the examinees.

There has been a steady 10-year decline in the number of new cases of active tuberculosis discovered among Veterans Administration patients admitted for treatment for diseases other than TBc and among the agency's employees. The VA uses tuberculin tests and chest x-ray examinations to screen all its hospital and clinic patients, its employees and volunteer workers. Interestingly enough the rate of new cases is slightly lower among employees

of VA TBc hospitals as compared with VA employees of general medical and surgical hospitals.

Hospitals in the U. S. established a new high in admissions in 1960—25,027,152, an increase of six percent over 1959. The ratio of admissions to population went up from 133.7 per 1,000 to 139.1. Other interesting statistics from the Guide Issue of *Hospitals*—The average length of stay in nonfederal short-term hospitals was 7.6 days, down from 7.8 in 1959. One factor in the short stay is the cost per patient per day—\$33.23. The ratio of employees to patients in voluntary short-term hospitals increased slightly; to 232 employees per 100 patients, up by three over 1959. Payroll expense amounts to two-thirds of all expenses.

Retail drug prices since 1949 have risen about half as much as total medical care costs and slightly less than the cost of living. When it is considered that modern drugs are not only more costly to produce but also much more potent and efficacious the fact that their price to the patient has risen only in concert with all other prices is remarkable indeed. In April the *American Druggist* reported that most prescriptions are priced at \$1.25, \$1.50 and \$2.00. Prescriptions costing \$10.00 or more make up only 1.5% of all prescriptions sold. The average price is \$3.25. Americans are buying more prescription drugs today—expenditures in 1959 were three times as much as in 1949. This is partly due to the fact that some of the best drugs today did not exist 10 years ago.

Accidental aspirin poisoning in children revealed some characteristic findings as reported by Dr. Roger J. Meyer after he had studied 94 cases which occurred in Boston. Of the 94 cases:

93 children had been told the pills were candy

84 children took flavored aspirin.

62 children shared the tablets with playmates.

In 73 cases aspirin had been used to treat another member of the family.

In 56.5% of the cases the aspirin was taken within an hour before mealtime. ◀

President's Page

PARTICIPATION OR NON-PARTICIPATION?

Because almost all of us are endowed with characteristics we attribute to "human nature", it is probably accurate to say, even though it sounds like a terribly selfish viewpoint, that each is interested primarily in his own welfare and his association with any organization, be it medical or other, is incidental to his quest for survival.

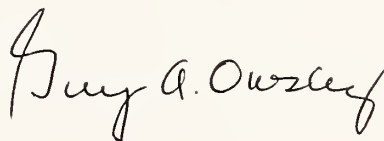
This expression may at times become confused in the minds of many and one may remain "on the fence" for long periods of time before one comes to the realization that his negative action is not in his best interest.

In this connection, I would like to use two areas of activity, engaged in by your State Medical Association, in which your leadership has either been wrong in taking positive action or too many remain "on the fence", as evidenced by their continued non-participation. I refer first to the Indiana Health Organization for Political Education, and second to the Headquarters Building project of the Association.

In the first instance there can be little disagreement with the necessity for physician participation in government and/or politics. That is, if you want to survive. It would seem then that the only reason for lack of participation through absence of contributions (only one-eighth of the membership is presently participating) is either your doubt in the method of approach, your resignation to the inevitability of government control, or the hope that someone else will provide the need. Disregarding the last two reasons for non-participation let us ask the question—Who can I trust to handle my contributions more than those who share my common interest? If one cannot find a negative answer to this question, there is no logical explanation for non-participation.

In the second area of activity, The Headquarters Building, where contributions play a major part, the score is better, but not good enough. In this case one-half of the membership have made substantial contributions and if all would participate equally there would be no need to borrow ANY money to complete the project.

As one leaves the office of President of our Association, it seems more appropriate to call attention to those things where one feels a better job should have been done and to hope that those who follow will have more success in the areas under discussion.

A handwritten signature in dark ink, reading "Guy A. Owsley". The signature is written in a cursive, flowing style with a large initial 'G'.

The Woman's Auxiliary

REPORTS TO ISMA

Our Program Book is now in hands of all the county presidents and presidents-elect. This is our Auxiliary workbook. I would like to share with you an article written by our President-Elect, Mrs. Thomas W. Johnson:

ORGANIZATION

"We, the American people, are confronted by an ever increasing tax rate. We want those things that our tax dollar provide for us—the basic freedoms of a free people; freedom from fear through our National defense, freedom of religion, freedom of speech, freedom of the press, and a representative government—a democracy where all men can live in peace.



"We also want freedom from want, freedom from illness, pain and suffering. But is it the obligation of our Federal government to provide all this? Or can we, through existing channels, provide adequate medical care for America's millions? Social Security we have—benefits go to the rich and poor alike, as long as they have paid into the plan. Now, some are seeking medical care for the aged under Social Security. What about all those elderly people in need who are not covered by Social Security? Where would they enter into this picture?

"Already, we have the Kerr-Mills bill which supplies Federal funds to supplement State funds, and all this is administered at the local level where the need is best known. Under the provisions of this bill, all our needy older citizens can have the care they need, and many State legislators have supplemented this bill with laws of their own. Our doctors cooperating with local government, are meeting the need, meeting it more effectively and efficiently.

"So let us, as doctors' wives, speak up for what we believe. Let us all take an active part in our Auxiliary—keep informed on these issues so vital to all people.

"It is my privilege this year to serve the Auxiliary as President-Elect. My job is that of organization. There are unorganized counties in Indiana. Even in cases where it is difficult or almost impossible for these groups to carry out all of the Auxiliary's program, they could still perform a valuable function by organizing and electing officers, so that they may be more easily reached. The more doctors' wives we can reach, the greater the results of our efforts."

There are 19 unorganized counties in the state. They could possibly be organized into ten constituent auxiliaries. If those of you who live in counties where there is no auxiliary, can see the value to the Medical profession and to community health of an organized auxiliary, perhaps you can help. Mrs. Johnson is working through every possible channel to organize these counties, and an assist from the doctors themselves would be most welcome.

Eji Kentner

Modern Drug Research

JOHN J. TOOHY

New York, N. Y.*

CHANCE is an unacceptable companion to the contemporary scientist educated in the experimental method and accomplished in its practice. In our time, empiricism has given way to sound investigational procedure and with practical benefits, as may be seen from the giant steps forward taken in technical knowledge since the early years of the century.

Contrary to popular belief, the basic research breakthrough is rarely an isolated discovery stumbled upon by accident. There is no more conspicuous example of the fruitfulness of the planned research program than the profusion of safe and effective prescription drugs now available because of the ordered synthesis, screening and study of chemicals for use as medicines. Of the 989 drugs described in the U.S. Pharmacopeia XVI, 306 or almost one-third of the total are new.

It has been estimated that about 70% of the prescriptions written today could not have been filled 25 years ago and that almost 45% were not available five years ago. Numerous compounds have been developed in virtually every known class of drugs. This exceptional activity has not only produced an abundant supply of medicinal agents but has also led to the more precise evaluation of each promising compound. The synthesis of a new agent often has been

followed by the evolution of new test procedures to accommodate a singular situation. In the process, knowledge of drug action as well as the general caliber of drug research has advanced appreciably.

At present, the modern medicinal agent must withstand the most critical scrutiny before it is released to the practicing physician. In contrast, some of the respected older remedies made their entry into the medical armamentarium purely through an empirical practice encompassing years of trial and countless numbers of patients.

A Backward Glance at Therapeutics

Some highly esteemed drugs, the naturally occurring plant alkaloids, for example, have been administered to humans in impure form to combat a disease entity, a symptom, or a symptom complex long before their composition was known. All are dangerous poisons when taken too frequently or in too large quantities. The classic examples are quinine, morphine and digitalis.

The history of these and other medically important alkaloids is similar in essential details. At first, the medicinal properties of the parent plant became known and were applied on an empirical basis among native populations in areas where the plant flourishes. With a favorable experience, information concerning preparation and use is disseminated and ultimately reaches Western civilization. This may have taken centuries in some instances. Western

* General Manager, E. R. Squibb & Sons Division of Olin Mathieson Chemical Corporation, and a member of the board of directors of the Pharmaceutical Manufacturers Association.

MODERN RESEARCH

Continued

medicine, in turn, has employed these remedies in crude preparations without the benefits of such modern concepts as purification, analysis and determination of safe dosage. Derivation of the composition of botanicals and attempts to control their variability or to extract and possibly synthesize the active principle are largely twentieth century phenomena. Even today, a potent pure principle of digitalis is an objective that has yet to be achieved.

Because of its appearance in Western circles during the past decade, *Rauwolfia serpentina* was subjected to the involved process of investigation common to all modern medicines. In this case, an empirical experience, several hundred years old, was promptly confirmed and enhanced through chemical and pharmacological study. Chemical analysis identified at least 23 alkaloids present in the whole root. In the experimental animal it was demonstrated that reserpine was largely although not wholly responsible for the medicinal properties of the plant. In time, the chemical structure of reserpine became known and the material was prepared synthetically.

Pharmacologic investigation of *rauwolfia* defined a multiphasic activity pattern composed of sedative, hypotensive, bradycardic and miotic effect as well as a significant influence on gastrointestinal motility. A new biologic assay procedure was devised, centered about the measurement of the ability of increasing doses of reserpine to induce relaxation of the nictitating membrane and ptosis. A definite correlation was found to exist between the degree of ptosis and sedation. The unusual quality of the sedation produced by whole root *rauwolfia* and reserpine was subsequently characterized as tranquilization. Thus psychopharmacology became the new frontier for the medical sciences. The rapid and continuous discovery of antibiotic substances following the initial work with penicillin is directly attributable to the availability of modern bacterologic and immunologic methods. Today, a single finding can trigger a chain reaction of experimental effort which may well turn up unexpected therapeutic dividends.

Changing Character of Drug Development

The modern medicinal agent is born of the collective experience of the pharmaceutical company research staff, the clinical investigator,

and their colleagues working in the basic sciences. More is known about new drugs than old, even before clinical trial in humans. Knowledge of the relationship between chemical structure and pharmacologic action has opened new avenues for the synthesis of medicinal compounds. Instead of uncontrolled origins in folklore and empiricism, most new drugs can present a respectable line of ancestors consecutively prepared by realignment of molecular constituents. Organic synthesis has proved a gainful approach to more effective and better tolerated medications.

The medicinal compound proceeds to pharmacologic testing in laboratory animals. Although its action may be predicted to some extent from its chemical character, a thorough investigation of activity and toxicity is instituted. Innovations in test procedures introduced to provide a yardstick where none existed attest to the ingenuity and competence of the scientist. One of the most interesting control procedures mothered by necessity is the use of the Siamese fighting fish (*Betta splendens*) to appraise the effect of tranquilizing drugs. Under normal conditions, these fish expand their pectoral fins and branchial membranes with flushing and fight to the finish. Hypnotics, sedatives and analgesics fail to interfere with the fighting. On the other hand, tranquilizers and antihistaminics depress and block the fighting response.

To indicate the potential anti-inflammatory activity of a corticosteroid in man, the direct inhibition of the inflammatory response in animals is measured by means of the cotton pellet granuloma technic. Cotton pellets weighing 5 to 7 mgms are inserted subcutaneously in rats, in the dorsal area of the ribs, immediately after bilateral adrenalectomy. One pellet is placed on each side of the spinal column. The animals are maintained with saline solution in place of water. Aqueous suspension of test corticoids are injected intramuscularly twice daily for six days. On the seventh day, the animals are sacrificed, and the pellets along with the encapsulating granulation tissue are removed. The dry granuloma weights are obtained after heating at 80° C overnight. Subtracting the original weight of the cotton yields the net granuloma weight.

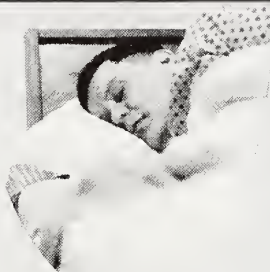
When the action, site and mechanism of action and unwanted effects have been demonstrated in the experimental animal, the drug is almost ready for trial in human beings. The

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lasts all night*

*only one
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This regulated therapeutic continuity maintains the dependable anticholinergic activity of PRO-BANTHINE all day and all night with only two tablets daily in most patients.

New PRO-BANTHINE P.A. will be of particular benefit in controlling acid secretion, pain and discomfort both day and night in ulcer patients and in inhibiting excess acidity and motility in patients with peptic ulcer, gastritis, pylorospasm, biliary dyskinesia and functional gastrointestinal disorders.

Suggested Adult Dosage: One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of PRO-BANTHINE P.A. or standard PRO-BANTHINE to meet individual requirements.

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Research in the Service of Medicine

MODERN RESEARCH

Continued

route of administration must be established on the basis of a number of factors. Among these are solubility, vehicle, desired site of action, concentration attained at this site and the speed and duration of action. The range and gravity of toxic manifestations must be considered before the drug is made available for human use. The minimum lethal dose established in laboratory animals must be sufficiently greater than the therapeutic range to insure safety. Even then, ample laboratory experience working with the drug is usually obtained before the transition to human subjects is made.

The increase in knowledge and information concerning the safety and activity of therapeutic agents which has occurred in the past decade is reflected in the new drug application. More basic biochemical and pharmacologic research is presented now in support of claims for efficacy and tolerance. The classic example is the exploration of sulfonamide mechanisms which disclosed the blocking of paraminobenzoic acid metabolism in bacteria as the factor underlying the bacteriostatic effects of these substances. Even the control procedures described are more specific, more accurate and more sensitive. Continuous recording spectrophotometers are commonplace and such technics as gas chromatography, x-ray diffraction and the falling drop electrode polarograph method have found application. It may reasonably be assumed that this process of change is continuous so that the unusual soon falls into the category of the common, making place for new concepts and new speculation.

Clinical Evidence in place of Clinical Impressions

The Food, Drug and Cosmetic Act requires that a new drug be tried in human beings before it can be marketed. Clinical behavior of the compound is properly defined in terms of age and sex of the patient, conditions treated, dosage, frequency and duration of administration, results of laboratory and clinical examinations, and observations of therapeutic benefits and adverse effects. The Food and Drug Administration asks for more information now than previously—the kind and amount depending upon the nature of the drug and the indications. Sketchy and incomplete clinical reports in the form of testimonials are not acceptable. The re-

sponsible investigator recognizes the importance of rigid experimental controls and the use of statistics in drug evaluation. Where assessment consists of the subjective reactions of the clinician to the subjective response of patients, as with the psychopharmacologic agents, clinical impressions reported with earlier compounds have given way to adequate experimental design, randomization, controls and statistical consideration.

In the past decade, drugs which exhibit multiple unrelated pharmacologic effects and create special problems with regard to clinical study have been introduced. The best examples are the several derivatives of the phenothiazine series. They possess the diverse properties of central depression including antiemesis as well as weak adrenolytic, hypotensive, antispasmodic, hypothermic and antihistaminic effects. With agents having diverse systemic influences, the observation of unwanted reactions or their absence is insufficient consideration of safety.

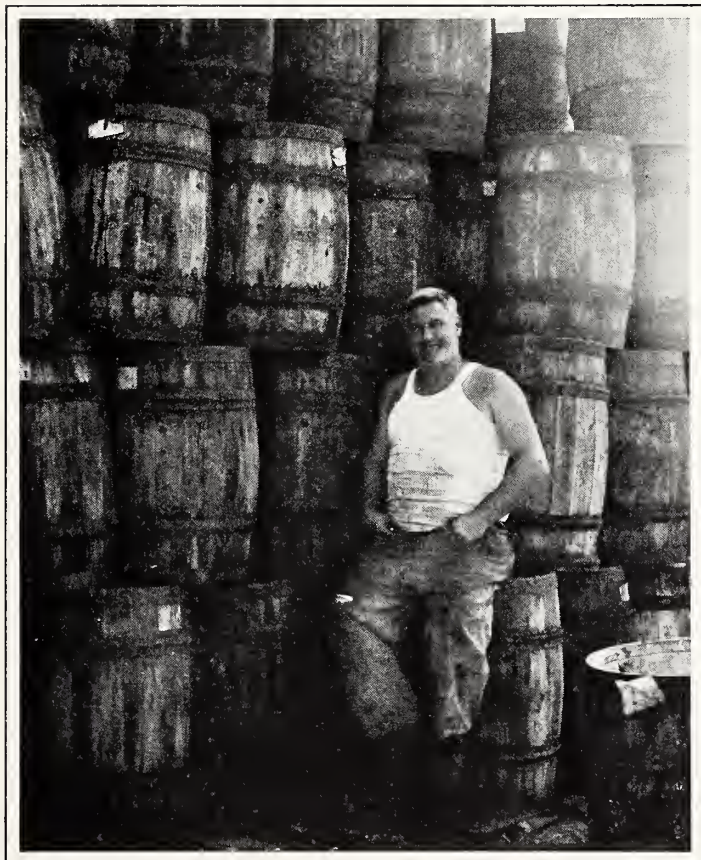
In addition, clinical chemistry procedures are becoming more routine for the determination of possible organic or systemic toxicity of potent therapeutic materials. To assess early hepatic toxicity, transaminase determinations are indicated in patients receiving test medications. Various renal clearance technics are employed to evaluate early kidney toxicity. Bone marrow examinations for evidence of hematopoietic damage, liver biopsy and even testicular biopsy are carried out on a clinical level in the study of new drugs.

For purposes of comparison, consider desiccated thyroid and thyroxin introduced about 1917. Because thyroid deficiency was known to lower metabolism and to produce myxedema, considerable experimental work already had been carried out. Nevertheless, serious overdose reactions and fatalities occurred. If these experiences were associated with a new drug at the present time, the compound would undoubtedly be discarded although some attempt might be made to synthesize a more efficient and less toxic analogue.

While there has been no change in intent on the part of the Food and Drug Administration since it was first established as a regulatory body, the review of new drug applications has become more critical with advances in technics of investigation. Because new drugs appear with rapidity causing revolutionary changes in the

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Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop LABORATORIES
New York 18, N.Y.

1626M

MODERN RESEARCH

practice of medicine, the physician needs more and more facts. He wants to know the content, therapeutic effects and potential toxicity of the drug he is to administer to his patient. F.D.A. is increasingly concerned that he be supplied with sufficient information to permit intelligent use of the modern medicine.

Continued Widening the Channels of Information

Just as the pharmaceutical industry has made and will continue to make important contributions to the advancement of drug knowledge, it is fully aware of the responsibility for dissemination of that knowledge. Criticism heaped upon the promotional or throw-away piece has tended to obscure the channels employed to impart scientific information to the practicing physician. Many reliable firms supply the clinical investigator with basic copy containing the findings of all of the chemical and pharmacologic tests performed by staff scientists to establish the worthiness of the drug for trial in humans. As clinical studies are completed, the copy is revised to include significant observations.

A wider distribution of basic information occurs after the drug is marketed. The carefully composed basic brochure, which has been reviewed by F.D.A., contains a thorough description of the properties of the agent, indications

for use, administration and dosage, untoward reactions and, usually, some of the clinical material submitted by collaborating clinicians. At no time in the history of medicine has so much information been available for distribution as now. The facts about today's modern medicinal agent have been placed before the physician in the package insert, the full descriptive text in the producers' releases, and also in the reprints of professional articles regularly mailed or detailed to him. The throw-away piece is not the best source of comprehensive knowledge nor is it intended to be. On the other hand, informative scientific literature is available on the important agents in current favor.

Modern channels of communication are utilized in reaching the physician with news of research and development. Films, two-way radio and the closed circuit television broadcast are now accepted supplements to the printed word, the medical service representative, and the reference summary. It may be anticipated that as methods of communication advance they will be adapted to the sharing of scientific information. The legacy of leadership is a responsibility for providing the practicing physician with more efficient and beneficial therapeutic agents submitted to exhaustive pharmacologic and clinical assessment and described in detail in the sources of information he may readily consult. ◀



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DR. DON SCHLEGEL discusses surgical problems at Methodist Hospital.



ROBERT W. HARGER, M.D.

JACK H. HALL, M.D.

MAX S. NORRIS, M.D.

Indianapolis

Need for the Program

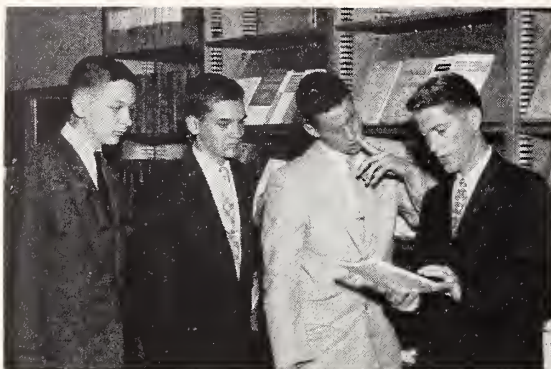
THESE ARE THE days when capable manpower is at a premium all over the world. Perhaps previous wars have been won on the playing fields of Eton, but surely the "cold war" will balance in favor of the country with the best classroom product. All of the scientific technical and professional fields want to take their students from the top of the heap. There is great competition here, and this phase of medical recruiting cannot be overlooked. Medicine must continue to enlist top scholars, but more than that, it must create a desire to excel in all capable young people.

In a recent nationwide survey made for the Boy Scouts of America, the Survey Research Center of the University of Michigan found that 83% of high school age boys want information on vocations. 94% of them want adult

leadership. Although current interests and activities take up a great deal of their time, their prime concern was overwhelmingly that of "what will my future occupation be?" Here lies a great challenge, and a golden opportunity for the American doctor to lead our students in what may be called the pursuit of excellence, and the students are asking for our help.

Here is a chance to provide motivation for students still in their formative years. How may they profit best from their high school and college experience? Will they be content with mediocrity, or will they rise to the test of superior accomplishment? Every student cannot be in the top five percent of his class; this is an opportunity to encourage interested young people to pull harder on the academic oar.

This provides the medical profession an unparalleled opportunity to work with those who have unusual records in high school scholarship and extra-curricular activities. Medicine itself is one of the greatest fields of exploration. We need medical specialists in statistics, electronics, space, radiation, engineering, mathematics, physics, chemistry, public relations, management, re-



A MEDICAL LIBRARY TOUR at Methodist Hospital was conducted by Dr. Jack Hall.

search, and teaching, AS WELL AS EXCELLENT PRACTITIONERS. The needs of the future will cause tremendous shortages in medical manpower, and these can only be met by vigorous programs of extension. WE DO NEED MEDICAL EXPLORERS!

Background of Explorer Scouting

Boy Scouts of America have always been anxious to provide programs of interest to the high school age group. Senior Scouting was developed some years ago and has recently been designated as Explorer Scouting. Explorers need no previous Boy Scout training or rank. They merely need to be age 15 or older. Most of the Explorer Posts (groups) have activities similar to the Boy Scouts such as camping, hiking, service projects and inter-group activities. The specialty program for Explorers has been available only recently. It includes such fields as aviation, banking, dentistry, civil denfense and emergency service, engineering, Indian lore, investments, journalism, judo, law, life insurance, marketing, marksmanship, medicine, pharmacy, professional scouting, ranger program, sea exploring, skin diving, scuba diving, spelunking (cave exploring), sports, transportation, theology and veterinary medicine. One approach suggests that Explorers be allowed to participate in one program one year and a different program the next. In this way they can evaluate various areas of interest. The Explorer Specialty program is similar in its goals and contributions to that of the Junior Achievement Program which has been so successful in the fields of business and industry.

The Boy Scout office can offer advisory and administrative support in these programs, but the actual implementation must come from someone in each specialty field.

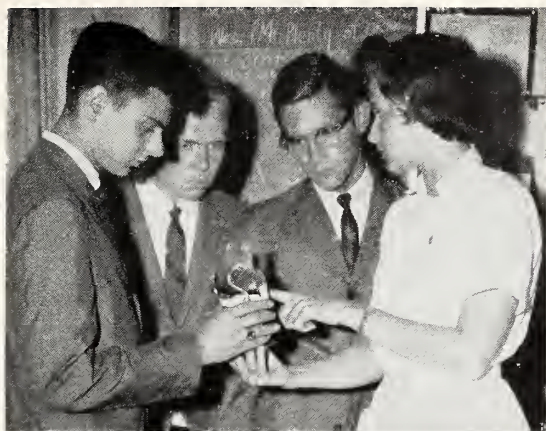
1961 Indianapolis Medical Exploring Program

A planning group met in December, 1960, and their curriculum committee developed the program which met for seven sessions during March through early June of 1961. Recruiting was handled through all of the Indianapolis high schools. Students were recommended by their science teachers, guidance counselors or high school principals. The academic requirement was simply that the school certify the Explorer to be capable of academic work necessary to become a medical student.

The planning committee consisted of Drs. John W. Beeler, Thomas C. Brown, Richard W. Dyke, Paul V. Evans, Charles Fisch, Jack H. Hall, Rolla N. Harger, Verne K. Harvey, Sr., Verne K. Harvey, Jr., Glenn W. Irwin, George T. Lukemeyer, Robert L. Parr, James D. Peirce, Edwin E. Pontius, Robert J. Rohn, Donald N. Schlegel, Chester A. Stayton, Jr., J. Edward Tether, Robert W. Harger, secretary, and Max S. Norris, chairman. Also included were Mr. Frank M. Chase, Mr. James Otto, and Mr. Graham T. Howard.

The curriculum committee was Mr. James Otto (Washington H.S.), Drs. Jack Hall, Charles Fisch, Max S. Norris, and Glenn Irwin.

For the pilot study it was suggested that two boys be chosen from the junior and senior classes of each high school. It was strongly felt that any capable student with proper motivation might reach a higher academic level stimulated by this program (and the program should not be limited to the top 10 or 20% in scholastic standing). The programs were held on Saturday afternoons from 1 to 3 o'clock. Of the seven



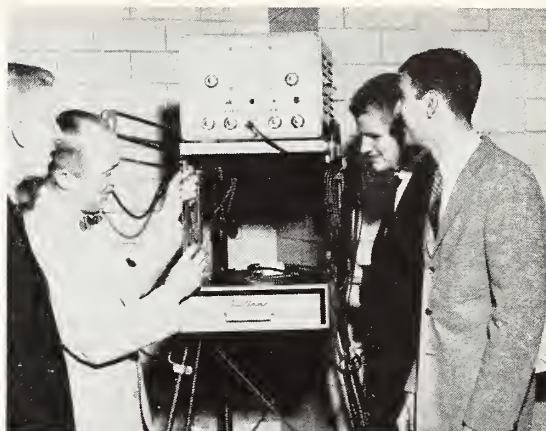
EXAMINING EQUIPMENT at the Indiana University Medical Center Blood Bank are Scouts Martin Gelman, William Birthright II, Fred E. Shick and Miss Zaetta Keller, technician.

meetings, three were planned for the entire group.

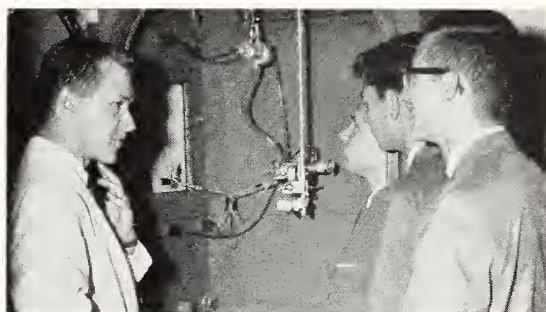
The first 45 minutes were devoted to medical orientation by a teacher, panel, or by some other means. One meeting was devoted to pre-medical, another to medical school, and the third to post-graduate interests. General sessions were followed by a tour or practical demonstrations as time permitted. Three more meetings were designed with the boys divided into three groups. Each of the groups met with a physician who presented a suitable two-hour program of his own concerning his specialty. For the pilot study, the fields of radiology, surgery, and laboratory were arbitrarily selected primarily because of their possibilities for general appeal. The final meeting was Preceptor Day during which the student accompanied a doctor in the field of his choice for the entire day. This began with breakfast and closed with a dinner meeting in the evening. During the afternoon a critique and evaluation session was held.

First Session: Pre-Medical Interests

The first session was held by Dr. Glenn Irwin, Associate Professor of Medicine at the Indiana University Medical Center. He discussed pre-medical and medical school curricula, the necessary academic requirements, work and job opportunities in medical school, scholarship and loan programs. A tour of the medical center followed, including the orthopedic ward and research wing of Riley Hospital, the Artificial Kidney Laboratory, Gross Pathology Museum, Gross Anatomy Laboratory, Bacteriology Laboratory, and Physiology Laboratory.



A DIRECT WRITING CARDIOSCOPE intrigues scouts visiting Methodist Hospital. Demonstrating the equipment is Dr. Dan Schlegel.



STUDYING THE TOTAL BODY PLETHYSMOGRAPH at the Pulmonary Physiology Laboratories of the I.U. Department of Medicine are Dr. Joseph Rass, Assistant Professor, and Martin Gelman, William Birthright II and Fred Shick.

Second Meeting—Radiology

The three groups met with Dr. Chester A. Stayton Jr. at St. Francis Hospital, Dr. Thomas C. Brown at Methodist Hospital, and Dr. John W. Beeler both at his private office and at the Radiology Department of the Indiana University Medical Center. They held brief discussions on the nature and science of radiation, demonstrating the processing and reading of films. One group took chest films of each other, completely processing them, and after an interpretation each was given his own film to take home. Equipment was inspected including the fluoroscopic examination of a barium swallow. They were shown the isotope labs including the simple principles of counting. One group observed guinea pigs which were being used for fat absorption studies. Radiation therapy was discussed, comparing the low and high voltage units with the new Cobalt units. Comparisons of hospital practice with private practice were given.

Third Meeting—"Why Go Into Medicine"

This was a general session held by Dr. Jack H. Hall, Director of Medical Education at the

MEDICAL EXPLORING

Continued

Methodist Hospital. His theme was built around the saying "The Luxury of Doing Good Surpasses All Other Enjoyment." Most societies recognize the practice of the healing art as a good endeavor. This is true the world over. A physician is a scientist in the true sense of the word and is able to follow this creed whether using the physics of refraction or the chemistry of fractionation. The opportunity for doing good in medicine is abundant and available to people of varying interests. In medicine the joy of one's work is even higher because so many of the answers are not yet known. This is the reason for the many long years of study and training that we undertake in preparation for the medical degree. His discussion was followed by everyone's having his blood pressure measured, and then a complete tour of the hospital facilities.

Fourth Meeting—Laboratory Sciences

Two of the groups met at the Methodist Hospital with Dr. Edwin E. Pontius and Dr. Paul V. Evans. The other group met with Dr. Robert J. Rohn at the Indiana University Medical Center. The boys were acquainted with laboratory methods and the pathologic background of modern medicine. Individual groups took tours of the facilities and saw some of the more interesting features of laboratory diagnosis, instrumentation and methods. They enjoyed a discussion of hematology basically centered around the peripheral blood smears. This was followed by a discussion of blood typing and blood groups.

Each boy examined a smear of his own peripheral blood and typed his own blood in the ABO group. At the I.U. Medical Center, they were able to visit the tumor induction laboratories and have a discussion with Dr. Hodes about the development of various tumors in mice and rabbits. Dr. James Ross demonstrated research equipment used in the study of lung tissue, and the basic functions of a research laboratory were outlined. In the hematology research section they studied slides with supravital staining.

Fifth Meeting—Cardiac Research

Postgraduate opportunities was the theme of this meeting with Dr. Charles Fisch and Dr. Edward Steinmetz at the Marion County General Hospital, Robert Moore Heart Clinic. They discussed problems of research and the use of

higher mathematics in calculation of cardiac output. They observed an open heart experiment in the animal laboratory* demonstrating the bypass pump for removal of carbon dioxide. They were shown the heart clinic, cardiac mock-up, and given explanations of the value of cardiac catheterization. Observations were made on each other's heart beats with the image intensifier and of their own heart sounds with the electrocardiograph tracings. Each of the Explorers was given a sample tracing of his EKG.

Sixth Meeting—Surgical

Surgeons who met with groups of Explorers were Dr. Don Schlegel at the Methodist Hospital, Dr. Joseph R. Eastman at St. Vincent's Hospital, and Dr. Wayne Thompson at Community Hospital. They gave brief outlines of their personal careers and education, discussing various aspects of specialty training for surgery. The personal life of a surgeon was included here, covering the hours of his work, problems and different types of surgery. The boys were allowed to inspect the operating room and various pieces of equipment used during surgery. They participated in a simulated surgery including full scrub, surgical gowns, gloves, masks, etc.

Final Meeting—Preceptor Day

Explorers and their physician-sponsors met at 7:30 a.m. for breakfast at the Methodist Hospital as the guests of Mr. Jack Hahn, the Superintendent. Mr. Hahn outlined the importance of medical administration and the group proceeded from there to visit the medical record department and the medical library. Each Explorer then went with his physician-sponsor for the day to follow him in his work. The entire group gathered again at 4 p.m. at the Indiana University Medical Center Union Building for a critique—question and answer period followed by dinner and a speech by Dr. John Mahoney, Assistant to the Dean of the Medical Center. Dr. Jack Campbell (the Jack Parr of IUMC) was master of ceremonies, and the Scout Executive of the Central Indiana Council, Mr. Frank Chase, spoke briefly.

Explorers' Conclusions

Conclusions from the critique were as follows: the program of Medical Exploring is of great

* Of the 20 boys only one fainted in the heart lab, a "good" average!

Continued

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venous techniques in therapy; an approach to asepsis in anesthesia; cardiac resuscitation and respiratory resuscitation. The new external cardiac massage procedure is fully described and illustrated. New material is also included on: monitoring during anesthesia; vaporization of anesthetics; controlled hypotension; hypothermia; treatment of the comatose patient; etc.

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MEDICAL EXPLORING

Continued

interest to boys who want to become doctors. It gives them a good idea of what is involved, through tours, live demonstrations and lecture sessions. They felt that it could run every other Saturday all winter. They were especially glad to see the Medical School and learn more of the requirements for admission. They asked to have more lecture time as this would allow them to cover more ground in "getting the feel of the profession." They also asked to be allowed to attend lectures given to medical students at the Medical Center. They preferred to tour specific sections of a hospital rather than the longer overall tours.


Those who had not already toured the Eli Lilly Co. would like that added to the program. There was a great preference for the small group meetings as compared with the larger sessions. They asked that if a program were going well that it should not stop at the two-hour limit but be allowed to continue. Many hoped that this could be tied more closely to their school program and actually be made a part of the school day. Perhaps some of the discussions could take

place right in their own high schools. More laboratory participation was requested by some. This would include laboratory projects and live demonstrations.

All agreed that the high school counselor or classroom science teacher should be the one to choose who might be in the program. The general feeling was that weekday afternoons would not be as acceptable as Saturday afternoons, except for those sessions which might be held as a part of the school day. Most of the Explorers felt that the program could easily be confined to juniors and seniors and should definitely include not only those who are already interested in pre-medical work but also those who have not yet decided their college course. They were all most appreciative of the attitude and personal touch of Preceptor Day sponsors as well as the generous acceptance of the Explorers by all the hospitals.

Dinner at the Medical Center

Remarks of Dr. John Mahoney, Assistant Dean of the Medical Center, were concerned largely with the new and more liberal admission requirements and the wide variety of scholastic



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background contained in the present day medical school class. Actually almost any college background can lead to medicine so long as the applicant has a degree or is eligible for a degree. They merely need to have chemistry, including organic and one year of physics, plus one year of animal biology (which can be either physiology, zoology, or developmental anatomy).

He made a survey of the present freshman class and found that among a total of 178 there were 46 varsity athletes. There were students with degrees in drama, journalism, philosophy, mathematics, language, history, political science, business, chemistry, and biology. Such men are well-rounded in their background and pursuits, and they have all been serious in their preparation. But they have obviously had many other interests besides their classroom studies. Each of the Explorers was presented with a booklet entitled "Admission Requirements of American Medical Colleges Including Canada 1960-61."

Preceptor Day Sponsors were Drs. John W. Beeler, Jack H. Hall, Robert W. Harger, Mr. Jack Hahn, Drs. Max S. Norris, Lewis E. Morrison, Louis Spolyar, Phil White, Dwight Schuster, Karl Manders, Doug White Jr., Herschell Moss, Paul Merrell, Ralph Streeter,

Austin Gardner, Don Rogers, George Teter, Jack Schofield, and Charles Gillespie.

Comments and Plans for the Future

Possibilities for Medical Exploring are limitless. The goal of the program is to give junior and senior high school students as much information about medicine in its broad connotation as time, facilities, and their academic status will allow. We hope to attract capable young people into medicine as well as present an orientation program that will be interesting and instructive to those who may go into other fields. The American Medical Association has long been on record as encouraging the time-honored duty of practicing physicians to help train medical students. And in recent years to this has been added *the strong obligation to help recruit medical students.*

Academic requirements for Medical Explorers are simple: merely that the high school certify that the Explorer is capable of academic work necessary to become a medical student. The basic curriculum covers such items as the pre-medical years, medical school itself, and finally postgraduate medicine and medical practice. This



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MEDICAL EXPLORING

Continued

program is not limited to boys, for suitable administration can be worked out with the Girl Scouts Senior Program to make the groups co-educational.

Medical Exploring is not limited to the area or county having a medical school. It is applicable to all counties where there is interest in medicine. The program can easily be built around any local medical society and hospital facilities. There are countless teaching aids such as film strips and movies which can be used to supplement the program. Medical Exploring cannot be just another department of the Medical School. It is far more appropriate that it become an integral part of each county medical society working with the young people of its community. Like the hand that rocks the cradle, so the hand that gives the pre-school physical exams and childhood immunizations should have a real part in shaping the destiny of our future doctors.

In order to expand this activity to fulfill its purpose, many more doctors in private practice

will be encouraged to accept assignments in the Medical Explorer program.

In addition to the activities that can be built around the branches of medical practice, another phase can easily include periods of service in our hospitals. This could be similar to the "Candy Stripe Girls" who serve as volunteers for the nursing services. Medical Explorers need not be a source of free service for our hospitals, but surely exposure to the details of day-to-day work will give them greater insight to future problems. Summer session workshops in Medicine can be built around community hospitals as well as medical centers. Similar programs have been especially useful in the laboratory sciences and technical fields. In pointing toward our goal of 250-300 Explorers for the Central Indiana Council area we expect to expand to 70 or 80 students for the 1961-62 school year.

Scouting has come a long way from fire-without-matches and overnight hikes, but Medical Exploring should be mutually useful to both the general public and the medical profession.

MEDICAL EXPLORERS TAKING PART IN THE 1961 PROGRAM

Group No. 1

Kurt Behrman
North Central High School
Charles Gillespie, Jr.
North Central High School
William Clark Hoff, Jr.
Howe High School
Craig Johnson
Washington High School
Kyle Pruett
Shortridge High School
Harvey Schuchman
Broad Ripple High School

Group No. 2

Michael D. Adeney
Broad Ripple High School
Jerry Baumgardner
Technical High School
William L. Birthright II
Broad Ripple High School
Edmond Brown
Crispus Attucks High School

William M. Hicks
Washington High School
William Morrow
Crispus Attucks High School
Jack W. Robertson
Technical High School

Group No. 3

Martin L. Gelman
Shortridge High School
Ron J. Jade
Shortridge High School
Fred E. Shick
Howe High School
Bill Stone
Broad Ripple High School
Morris Tabak
Harry E. Wood High School
Steve Crockett
Broad Ripple High School
Steve Heise
Washington High School



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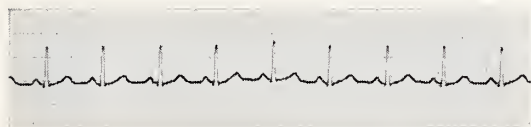
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Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Doctor's own words may prove his negligence—Statements made by a gynecologist to a patient and her husband after an operation were sufficient to provide expert evidence of negligence in diagnosis to submit to a jury. A dismissal of the patient's damage suit for lack of evidence was reversed on appeal by the Oklahoma Supreme Court.

Consulted by the patient, the gynecologist made tests and determined that she was not pregnant but has a tumor which should be removed immediately. Upon operating, however, he found that she was, in fact, pregnant. The patient testified that, after the operation, the gynecologist said to her, "I'm sorry, I should have made more tests on you." Her husband testified that the gynecologist said, "... this is a terrible thing I have done, I wasn't satisfied with the lab report, she did have signs of being pregnant. I should have had tests run again, I should have made some other tests. I'm sorry."

Although there was no expert testimony that the gynecologist was negligent in making his diagnosis, the appellate court held that the testimony as to his admissions was sufficient to go to the jury. Two justices dissented, stating that, although the gynecologist recognized that he had made a mistake after the operation, his statements did not amount to admissions of negligence. — *Greenwood v. Harris*, 362 P. 2d 85 (Okla., May 31, 1961).

No damages for rupture of esophagus by gastroscope—In attempting to insert a gastroscope to verify a diagnosis of antral gastritis, a phys-

ician ruptured a patient's esophagus. An emergency operation was required to repair the rupture, since air leaked into the pleural cavity and caused a partial collapse of one lung. The operation required removal of one rib, and caused severe pain and a large disfiguring scar. A damage suit by the patient against the physician was dismissed without submission to the jury, since there was no testimony of an expert medical witness that the physician had been negligent.

Charitable hospital liable for damages in fall of child visitor—A charitable hospital in New Hampshire was liable for damages where a six-year-old girl fell from an unguarded retaining wall seven to nine feet high. The girl, who was not permitted to enter the hospital, was visiting "through the window" with her aunt who was a patient in the hospital. While playing with her brother outside the window, the girl fell from the retaining wall. A verdict in favor of the girl was upheld by the State Supreme Court and a judgment was entered thereon.

The Supreme Court held that a charitable hospital is not immune from liability for negligence. It said that the evidence was sufficient to permit a finding that the hospital created and maintained a hazard which was a known dangerous condition not likely to be appreciated by young children in the absence of an adequate warning. This was sufficient to constitute negligence. — *Wheeler v. Monadnock Community Hospital*, 171 A.2d 23 (N.H., May 31, 1961).

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MEDICINE AT LAW

Continued

No damages for death of patient after cardiac arrest during operation—A woman patient died after she suffered a cardiac arrest while undergoing an operation with spinal anesthesia. Heart action was restored manually after an emergency thoractomy. There was indication of brain damage which could have been caused otherwise than by lack of oxygen.

Negligence was alleged in the failure of two anesthetists to place on a respirator a bag which would have permitted more effective administration of oxygen and in the failure to record currently the details of the treatment. The evidence, however, showed that a bag was placed on the respirator and oxygen was administered before the manual heart operation began. Moreover, there was medical testimony that the administration of oxygen was of no value at all until heart action was restored.

The reviewing court upheld a judgment in favor of the anesthetists. It said that there was no medical evidence that the injury and death of the patient was caused by the alleged negligence

of the anesthetists.—*Erban v. Kay*, 174 N.E.2d 667 (Mass., Apr. 27, 1961).

Record verdict awarded in defective polio vaccine case—A verdict of \$600,000 for a young boy crippled by a dose of defective Salk polio vaccine which contained live virus was awarded by a San Francisco jury, together with a verdict of \$75,000 for his mother, according to newspaper reports. The verdicts were awarded against the Cutter Pharmaceutical Laboratories of Berkley, Calif.

The total award of \$675,000 is the largest that has been made in any personal injury suit. The damage claim was made on the basis of breach of an implied warranty. The attorney for the boy and his mother was Melvin M. Belli of San Francisco.

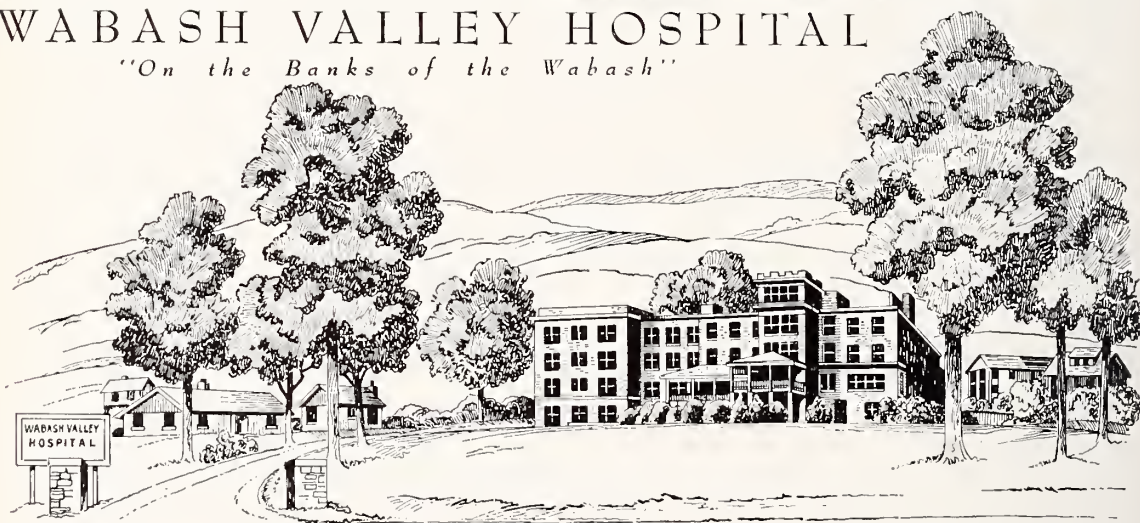
W. B. SAUNDERS COMPANY features the following recent books in their fall page advertisement appearing elsewhere in this issue:

Dripps, Eckenhauff and Vandam: *Introduction to Anesthesia*. An ideal basic guide to the understanding and safe administration of anesthesia.

Carday and Irving: *Disturbances of Heart Rate, Rhythm and Conduction*. Covers management of all the cardiac arrhythmias and conduction defects.

WABASH VALLEY HOSPITAL

"On the Banks of the Wabash"



A hospital for the treatment of Neuro Psychiatric Disorders
Open Psychiatric and consulting staff

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NEW...made from 100% corn oil

UNSALTED MARGARINE

FOR HYPERTENSIVE PATIENTS

- * contains only 10 mgs. of sodium per 100 grams
- * contains 50% liquid corn oil and 50% partially hydrogenated corn oil
- * has 30% linoleic acid—10 times that of butter

Because of the relationship of high-sodium intake to elevated blood pressure, new Fleischmann's Unsalted Corn Oil Margarine will prove to be a valuable addition to the dietary regimen of your hypertensive patients. It contains only 10 mgs. of sodium per 100 grams.

Fleischmann's Unsalted Margarine is made from 100% corn oil and contains both liquid corn oil and partially hydrogenated corn oil. Its linoleic acid content of 30% is three times higher than the 10% of regular margarines and ten times higher than the 3% of butter. This is the *only* unsalted margarine made from 100% corn oil.

The substitution of Fleischmann's Unsalted Corn Oil Margarine for butter or

ordinary margarines in your hypertensive patients' dietary regimen has the added advantage of increasing their intake of high polyunsaturates . . . important because of their association with hypertension and atherosclerosis.

If your hypertensive patient needs sodium restriction, recommend Fleischmann's Unsalted. It has a light, delicate taste that he'll like. Tell him that it is available in his grocer's frozen food case.

Write now for physician booklet of 5 coupons—each coupon redeemable by your patient for 1 lb. of Fleischmann's Unsalted Margarine. Address Fleischmann's Unsalted Margarine, 625 Madison Avenue, N. Y. 22, N. Y. *Distribution presently limited in some areas.*

In line with the suggestion of the American Heart Association to manufacturers, we are listing the fatty acid composition of Fleischmann's Unsalted (Sweet) Margarine:

Unsaturated Fatty Acids:

Polyunsaturates 30%
Monounsaturates 50%

Saturated Fatty Acids 20%
100%



Fleischmann's

Fresh-Frozen in the green foil package
in your grocer's frozen food case

AVERAGE DAILY INTAKE

Two Ounces or Eight Pats of Fleischmann's
Corn Oil Margarine Will Supply

Corn Oil—Liquid 22.7 Gm.
Corn Oil—Partially Hydrogenated . . . 22.7 Gm.
Iodine Value 90-95

Sodium (dietetically sodium-free) . . . 6 Mgs.
Linoleic Acid 13.6 Gm.
Vitamin A (Adult's Need) 47%
Vitamin A (Child's Need) 62%
Vitamin D (Adult's and Child's Need) . . . 62%

**ONLY UNSALTED MARGARINE
MADE FROM 100% CORN OIL**

Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.

Indianapolis

Two studies by Krut, Perrin and Bronte-Stewart^{1,2} appear to confirm what any maitre de hotel has suspected for many years. It was shown that cigarette smokers tend to have some decrease in taste sensations for bitter substances. Likely as an effect of this first study, it is shown that smokers tend to eat more highly spiced foods. They also eat a somewhat larger percentage of fat, as shown on dietary comparisons with non-smokers. Smokers' tastes for sweet, sour and salt were not affected. Heavy smokers ate more meat and eggs than did non-smokers. These studies were done in Capetown, South Africa, even though they were supported in part by research grants from the United States National Heart Institute, so perhaps it will lead to our shipment of surplus cigarette filters to this area via another grant. This observation is the reviewer's, not the author's.

Previous studies had largely tended to support the theory that cromatin-positive Klinefelter's syndrome cases were found more frequently in patients who were mentally defective. An article presented by Israelsohn and Taylor³ questions this. Theirs is a large study, well-documented, and cites comparisons with many previous papers. They feel that the issue is not settled, and they point out that much of the preceding work has been done on institutional patients who were already mentally retarded. Perhaps previous authors have fallen into the same pitfalls as Buerger associating his disease with Jews, who constituted the large part of his hospital population. Another thought is the incidence of phenylpyruvic oligophrenia in blue-eyed, blond-haired children — as reported in Scandinavia.

James⁴ reports on 170 patients with erythema

nodosum who were observed by him at Royal Northern Hospital in London during 1950-9. Of interest is the breakdown of etiologic factors which appear to be quite different from what one would expect to find in the United States. 126 patients had sarcoidosis, while 21 had various infections (streptococcal 12, tuberculosis 4, pneumonia 3, dental abscess 1, and acute colitis 1) and in 23 a definite cause was not found. Other side interests from the study are that the Kveim test certainly is used more by James than in this area, and that there is little to do in the way of local treatment of the skin lesions.

Hamman's sign (usually a crunching or clicking sound near the cardiac apex) has been acclaimed to be diagnostic of pneumomediastinum. However, Semple and Lancaster⁵ report 24 patients in whom such a noise was heard, and 18 of these patients had shallow left-sided pneumothorax. Their description of this sound, being synchronous with the heart beat, etc. seems to fit the sound described by Hamman. Other recent papers have brought up this same association with pneumothorax, so the term "pathognomonic" no longer seems to fit this sign.

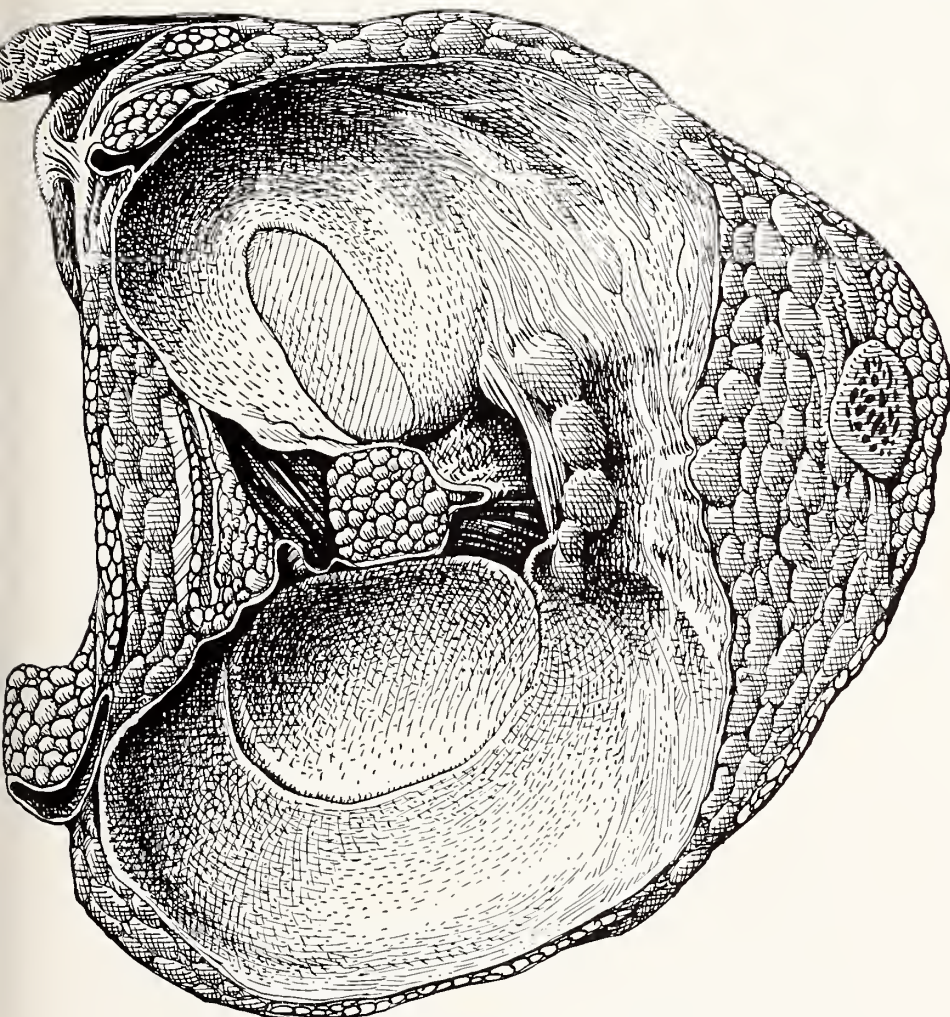
REFERENCES

1. Krut, L. H., Perrin, M. J., Bronte-Stewart, B.: Taste Perception in Smokers and Non-Smokers. *Brit. Med. J.* 5223 pp. 384-386.
2. Perrin, M. J., Krut, L. H., Bronte-Stewart, B.: Smoking and Food Preferences. *Brit. Med. J.* 5223: pp. 387-388.
3. Israelsohn, W. J., Taylor, A. I.: Cromatin-Positive Presumed Klinefelter's Syndrome. *Brit. Med. J.* 5226: pp. 633-635.
4. James, D. G.: Erythema Nodosum. *Brit. Med. J.* 5229: pp. 853-857.
5. Semple, T., Lancaster, W. M.: Noisy Pneumothorax. *Brit. Med. J.* 5236: pp. 1342-1346. ◀

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(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

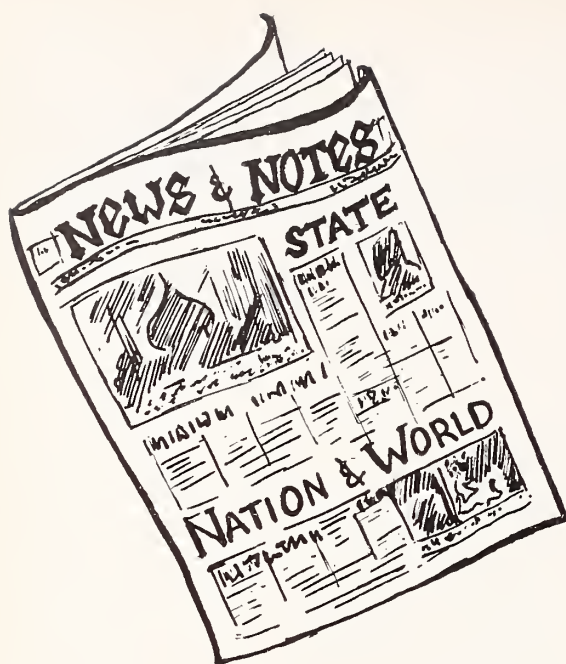
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ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

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Plan now to attend the A.M.A. Clinical Session in Denver, November 27-30



Thyroid Association Offers The Van Meter Prize Award for 1962

The American Thyroid Association, Inc. is again offering the Van Meter Prize Award of \$500.00 to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause." The studies so submitted may relate to any aspect of the thyroid gland in all of its functions in health and disease.

The award will be made at the annual meeting of the Association at the Roosevelt Hotel, New Orleans, La., May 9-12, 1962. A place on the program will be reserved for the winning essayist if he can attend the meeting. When more than one author's name appears on the manuscript the authors will be asked to designate a single recipient to receive the award.

The competing essays may cover either clinical or research investigations, should not exceed 3000 words in length and must be presented in English. Duplicate, typewritten copies, double spaced, should be sent to the Secretary, Theodore Winship, M.D., 430 N. Michigan Ave., Chicago 11 not later than January 1, 1962. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

Reference Book of Medicolegal Forms Available to Physicians

A reference book of medicolegal forms with legal analysis recently published by the AMA will be sent free of cost in single copies to physicians. Hospitals and non-physicians may obtain copies at \$1.00 each.

The 49-page book contains discussion of many medicolegal situations with form letters or forms to cover such contingencies as withdrawal of the physician from a case, discharge of the physician by the patient, leaving hospital against advice, failing to keep appointment, failing to follow advice, substitute physician, disclosure of information, and authorization forms to cover every conceivable development or proposed treatment.

Requests for copies should be addressed to Law Department, AMA, 535 N. Dearborn St., Chicago, 10.

AEC PERMITS REACTOR CONSTRUCTION

The Atomic Energy Commission has announced its intent to issue a permit to Purdue University for the construction of a one-kilowatt research reactor at West Lafayette for the purpose of research and student training. The reactor is expected to be completed by late this year or early in 1962.

Dr. Peck Retires from Lilly's

Dr. Franklin B. Peck, Sr., of Indianapolis, director of clinical research of the international division of Eli Lilly and Company retired on July 31. Dr. Peck has been with Lilly's for 25 years. His major work has been with insulin, diabetes and carbohydrate metabolism.

OB-Gyn Board Exam Scheduled for January

The next scheduled examination (Part I), written for the American Board of Obstetrics and Gynecology, will be held in various cities of the United States, Canada, and military centers outside the Continental United States, Friday, Jan. 5, 1962.

Current Bulletins may be obtained by writing to Robert L. Faulkner, M.D., Executive Secretary and Treasurer, 2105 Adelbert Rd., Cleveland 6.

Diplomates of this Board are urged to notify the office of the Executive Secretary and Treasurer of a change in address.

Drs. Robert Flaherty of Fort Wayne and Glen Ramsdell of Richmond were inducted as

Fellows of the American College of Chest Physicians during the annual meeting of the College in New York City in June.

Ames to Publish Abstracts For Medical Technologists

The Ames Company of Elkhart announces a new quarterly paper of abstracts to be mailed to medical laboratory technologists on their request. The new venture is named "Labquick" and will cover all the literature that is of interest to technologists. The American, Canadian and foreign journals will be covered.

Sidney Amy Appointed to Pitman-Moore Post

Sidney M. Amy, who served for eight years immediately after World War II as Chief of Special Services for the Indianapolis Veterans Administration Hospital, has been appointed Central Regional Sales Manager for Pitman-Moore Company. Mr. Amy was a Pitman-Moore sales representative in the Anderson-Muncie area from 1956 to 1959.

Dr. O. H. Wisheart, North Salem, has retired after more than 63 years of practicing general medicine in that community. ◀

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF "THE PROBLEM DRINKER"

*At The Keeley Institute your patients
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- the most modern, coordinated, comprehensive, rehabilitative regimen
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- full cooperation throughout with the referring physician
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FUTURE MEETINGS, SEMINARS, COURSES

AMA Clinical Meeting Set Nov. 26-30 at Denver

The 15th annual clinical meeting of the American Medical Association will be held Nov. 26-30 at Denver, with a program geared to basic problems of medicine faced by physicians in their practice.

An outstanding scientific program, with emphasis on new research developments, has been planned under the direction of Samuel P. Newman, M.D., Denver, chairman of the AMA's Council on Scientific Assembly.

Some highlights will include sessions and papers on such important areas of medicine as genes and chromosomes, electronics and computers in medicine, space medicine, medical aspects of American habits, new developments in virology, treatment of radiation injuries, new findings in chemotherapy for cancer and latest data in the field of antibodies and antigens, Dr. Newman said.

With more and more nuclear reactors coming into use all over the nation, many practicing physicians soon may begin to face the problem of treating injuries from radiation accidents, the chairman said.

A section of internationally known experts in the treatment of radiation injuries will offer three major papers in this important new area of medical care. Chairman will be Marshall Brucer, M.D., chairman of the medical division, Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tenn.

The radiation experts will discuss such topics as "Potential and Probable Sources of Radiation Accidents," "Diagnosis and Pathology of Radiation Injury" and "Treatment and Prognosis of Radiation Injury." Participants will include researchers from Los Alamos and Oak Ridge, the Office of the Surgeon General and the University of Chicago.

The age of advancing physical science also offers new findings to medical science: the use

of electronics and computers in medicine. Chairman of this section at the Denver meeting will be A. H. Schwichtenberg, M.D., head of the department of aero-space medicine, Lovelace Foundation for Medical Education and Research, Albuquerque, N. M.

Computer systems for recording medical data to aid the physician in his diagnosis and prognosis will be discussed. Topics will include "The Future of Electronics in Medicine," "Micro-electronics and New Concepts of Bioinstrumentation," "A System for Medical Data Recording," and "Biological Computers."

The virus, one of the most complex problems facing the clinician, will be the subject of a series of papers by outstanding specialists. Jonas E. Salk, M.D., Pittsburgh, originator of the killed virus polio vaccine, will give a paper on "Immunization Against Virus Diseases." Other topics will include "The Nature of the Virus and Its Cellular Reaction," "Smallpox Vaccination Complications," "Virus Hepatitis" and "Identification of Viruses."

"We are confident that the 15th annual clinical meeting will offer one of the most interesting and informative programs ever presented at the winter session," Dr. Newman said.

"The program is designed to assist the physician in his practice. The latest findings in many areas of medicine will be presented by men who are top specialists in their fields. The meeting will be of great value to the clinician in advancing his knowledge."

San Diego Postgraduate Assembly

The 15th Annual Postgraduate Assembly, sponsored by the San Diego County General Hospital will be held on Wednesday, Nov. 1, and Thursday, Nov. 2, 1961, at the County Hospital, San Diego, Calif.

Continued



*the medical summit
in the mile-high city...*

DENVER NOV. 26-30

AMA 15th CLINICAL MEETING

Denver—the hub of the Rocky Mountain states and air-rail-auto crossroads of the West—plays host to the nation's physicians next November by presenting the most vital, timely, and varied scientific program ever assembled at a winter clinical meeting.

Nothing in medicine is so new that you won't find it discussed or exhibited in Denver. Planned just for you—the physician in practice—a five-day session headlined by many of the nation's leading medical authorities offering a blending of "refresher" education with the most advanced knowledge, tools and techniques developed in recent research.

The entire scientific program is scheduled in one convenient location, Denver's Municipal Auditorium. Here are but a few of the many topical highlights:

PANEL DISCUSSIONS

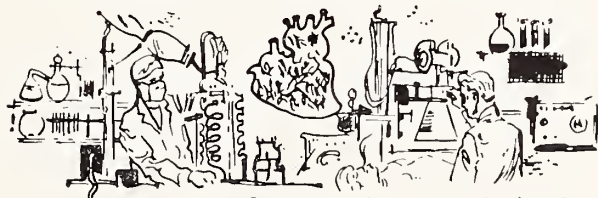
- Influence of Heredity on Disease
- New Developments in Virology
- Space Research—Impact on General Medicine
- American Habits vs. Health
- Advances in Chemo- and Radiotherapy
- Suicide—Causes and Prevention
- Medical Computers and Electronics
- Radiation Accidents and Injury
- Sunlight and Skin Care

BREAKFAST MEETINGS

- Community Psychiatric Care
- Malmstrom Vacuum Extraction
- Diagnosis in Pulmonary Surgery
- Pyelogram Clinics
- Poison Control Centers
- Dermatology Quiz Sessions



- MEDICAL MOTION PICTURE PREMIERES
- CLOSED CIRCUIT COLOR TELEVISION
- 215 SCIENTIFIC AND INDUSTRIAL EXHIBITS



For a medical meeting in depth in America's highest city

DECIDE NOW—IT'S DENVER IN NOVEMBER

See JAMA October 14 for complete scientific program . . . for physician advance registration and hotel reservations

American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

FUTURE MEETINGS

Continued

Postgraduate Diabetes Course Jan. 17-19 in Detroit

The American Diabetes Association will conduct its Tenth Postgraduate Course in the form of a clinical Conference in Detroit and Ann Arbor on Jan. 17, 18 and 19, 1962. The American Academy of General Practice will give 19 hours of Category II credit for the course. A fee of \$75 is charged nonmembers, \$40 for members of the association. Information and registration forms may be obtained by writing American Diabetes Association, 1 E. 45th St., New York 17.

ISMA MEMBERS INVITED TO PSYCHIATRIC MEETING

The American Psychiatric Association invites all interested members of the ISMA to attend its divisional meeting in Milwaukee, Nov. 16, 17 and 18. The program contains several panel discussions on subjects of general interest such as "Psychiatry and Mental Health Associations," "Psychiatry in the Schools," and "Present Status of Drugs and Psychiatry." The registration fee is \$5.00. Inquiries may be directed to the association at 756 N. Milwaukee St., Milwaukee 2.

I.A.G.P. ROAD SHOW

The first fall Road Show of the Indiana Academy of General Practice will be held at the Dela-

ware Country Club, Muncie, Nov. 1, 1961. Contact Dr. E. M. Gillum, local arrangements chairman, for details.

Course in Laryngology, Bronchoesophagology Offered At University of Illinois

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from April 2 through 14, 1962, under the direction of Paul H. Holinger, M.D.

Registration will be limited to 15 physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Ill.

Chicago Diabetes Association to Meet

The Chicago Diabetes Association will conduct its FIFTH ANNUAL SYMPOSIUM ON DIABETES at the Offield Auditorium, Passavant Memorial Hospital, 303 East Superior St., Friday, Nov. 10.

Speakers will include Dr. George F. Cahill, Jr. of Peter Bent Brigham Hospital, Boston; Dr. Paul E. Lacy, Washington University School of Medicine, St. Louis; Doctors G. de Takats, Marvin Cornblath and Theodore B. Schwartz, University of Illinois Medical School; Doctors Arthur R. Colwell, Sr. and Ralph E. Dolkart, Northwestern University Medical School; Dr. Albert Dorfman, University of Chicago Medical School; and Doctors William C. Shoemaker and Piero P. Foa, Chicago Medical School.

There will be a roundtable discussion at the luncheon recess at Abbott Hall, led by various speakers on the program.

Registration is free for members of the Chicago Diabetes Association or the American Diabetes Association and for medical students and resident house staff members. The fee for nonmembers is \$25.00.

Members of the Academy of General Practice may claim hour for hour credit in Category II.

Inquiries may be addressed to the Chicago Diabetes Association, 620 North Michigan Ave., Chicago 11.



"The girls at my club would be so tickled if you discovered I had some mysterious oriental malady!"

Deaths

William O. Baldrige, M.D.

A 57-year-old Terre Haute physician and surgeon, Dr. William O. Baldrige, passed away Aug. 9. He had practiced in Terre Haute since 1929.

Dr. Baldrige was a graduate of the University of Illinois and received his M.D. from that University's College of Medicine.

He was former vice president of the Vigo County Medical Society, and during World War II, was Army surgeon and commander of the station hospital and chief of surgery at both Los Angeles and San Francisco ports of embarkation.

Charles R. Bird, M.D.

Dr. Charles R. Bird, Indianapolis internist and physician for the Indiana State Police from 1933 to 1960, passed away Aug. 29 at the age of 85.

A graduate of Ohio Med. College in 1897, Dr. Bird did postgraduate work at Harvard University and in Vienna, Austria. He served in World War I with the British Army, coming to Indianapolis to set up practice in 1926. For 20 years prior to the war he practiced in Illinois and Greensburg. Dr. Bird was a Senior and 50-Year Club member of ISMA.

M. H. Draper, M.D.

Dr. M. H. Draper, medical director of the Irene Byron Sanatorium, near Huntertown, for 19 years, passed away in Florida Aug. 4. He had left Allen County in 1946 to become medical director of a sanatorium in St. Petersburg, Fla., but had recently retired.

Dr. Draper was a former president of the Indiana Trudeau Society, former director of the Allen County Tuberculosis Society and former president of the Fort Wayne Rotary Club.

Ivan Gilbert, M.D.

Dr. Ivan Gilbert, prominent Terre Haute physician for 35 years, passed away Aug. 29 at the age of 63.

A graduate of the University of Illinois College of Medicine, Dr. Gilbert was a Fellow of the American College of Surgeons and a Diplomate of the International College of Surgeons.

James I. Pregent, M.D.

Dr. James I. Pregent, 29-year-old Mishawaka physician, was killed Aug. 20 in an automobile accident.

Dr. Pregent was graduated from Indiana University School of Medicine in 1958.

Donald Reed, M.D.

Dr. Donald Reed, 60-year-old Culver physician, passed away July 18.

A graduate of Indiana University School of Medicine in 1931, Dr. Reed had practiced in Culver since 1932, with exception of four years during World War II, when he served as captain in the Air Corps.

Continued

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For your patients with infections or other illnesses who need therapeutic vitamin support. Each Theragran supplies the essential vitamins in truly therapeutic amounts:

Vitamin A	25,000 U.S.P. Units
Vitamin D	1,000 U.S.P. Units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Vitamin C	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B ₁₂	5 mcg.

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Squibb Quality—the Priceless Ingredient

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“nutrition...present as a modifying or complicating factor in nearly every illness or disease state”¹

1. Youmans, J. B.: *Am. J. Med.* 25:659 (Nov.) 1958

cardiac diseases “Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease.”²

2. Kampmeier, R. H.: *Am. J. Med.* 25:662 (Nov.) 1958.

arthritis “It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . .”³

3. Fernandez-Herlihy, L.: *Lahey Clinic Bull.* 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.⁴ Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.⁵

4. Sebrell, W. H.: *Am. J. Med.* 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: *Therapeutic Nutrition*. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases “Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult.”⁶

6. Overholser, W., and Fong, T. C. C.: in Stieglitz, E. J.: *Geriatric Medicine*, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.⁷

7. Goldsmith, G. A.: *Conference on Vitamin C*. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: *Medical Science* 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.⁸ “Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes.”⁹

8. Duncan, G. G.: *Diseases of Metabolism* 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: *Am. J. Med.* 25:708 (Nov.) 1958.

FOR FULL INFORMATION SEE YOUR SQUIBB PRODUCT REFERENCE OR PRODUCT BRIEF.

County News

Lawrence

Nineteen members of the Lawrence County Medical Society met at Bedford Sept. 6 for a business session.

Putnam

Dr. Robert M. Vandivier, Indianapolis, spoke to 15 members of the Putnam County Medical Society on Sept. 8 at Greencastle.

Shelby

Following a meeting Aug. 16, the Shelby County Medical Society announced that it will award a \$100 nursing scholarship to a student nurse this year.

A 1938 graduate of the I.U. Medical School, he had practiced in the East and at Rushville since 1946 until moving to Illinois 18 months ago.

W. Mitchell Taylor, M.D.

Dr. W. Mitchell Taylor, former Crawfordsville general practitioner, passed away Aug. 29 at his home in Ft. Lauderdale, Fla. He was a graduate of the I.U. School of Medicine, Class of 1940.

D. L. Wilhoit, M.D.

Dr. D. L. Wilhoit, 93, retired Martinsville physician, passed away Aug. 25. He had practiced in Martinsville for 65 years.

Dr. Wilhoit was a graduate of Louisville Medical School.

DEATHS

Continued

Robert B. Johnson, M.D.

Dr. Robert B. Johnson, former Rush County coroner, and Hope physician for the past six months, passed away Aug. 17.

A limited number of rosters and ISMA yearbooks are available at the Journal office, 1019 Hume Mansur Bldg., Indianapolis. Price—\$3.00 each.

THE PHYSICIAN AND THE CANCER PATIENT

The American Cancer Society is concerned with the **total** cancer problem. A crucial part of this problem relates to the cancer patient and his family. To help the medical profession explore ways and means of meeting the patient's special needs, the scientific session of the Society's next Annual Meeting at the Hotel Biltmore in New York City, October 23-24, 1961, will be devoted to "The Physician and the Total Care of the Cancer Patient." Various specialists will examine the psychological and physical problems facing the cancer patient and his family. Consideration will be given to such topics as decisions in the early care of the cancer patient, counselling the cancer patient, what the patient should be told, care of the advanced cancer patient, society's role in service to the cancer patient.

Through such meetings, the American Cancer Society serves the medical profession by providing a forum for an exchange of information and experience concerning the cancer patient.

AMERICAN CANCER SOCIETY



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FROM ACCIDENT & SICKNESS AS WELL AS
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**PHYSICIANS CASUALTY & HEALTH
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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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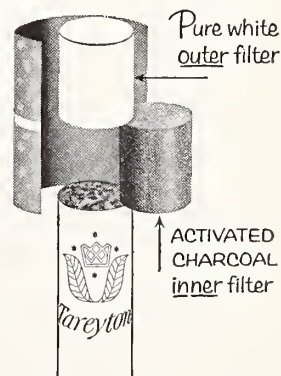
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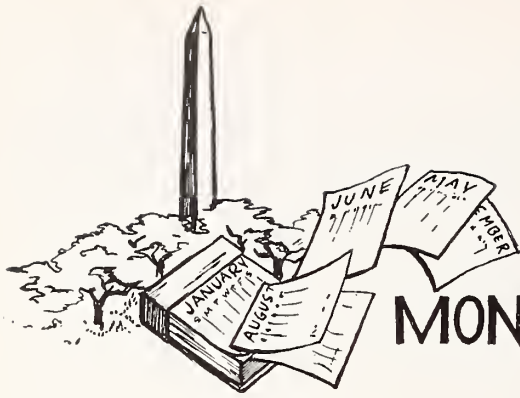
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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The American Medical Association and the federal government declared all-out war on medical quacks and charlatans who bilk the sick and gullible of hundreds of millions of dollars each year through useless gadgets, phony nostrums, fake reducing pills and the many other gimmicks of the medicine show trade.

The campaign was launched at the First National Congress on Medical Quackery, under joint sponsorship of the AMA and the U.S. Food and Drug Administration, Oct. 6-7 at the Sheraton-Park Hotel in Washington.

Among the keynote speakers were two top officials in President John Kennedy's cabinet, Secretary of Health, Education and Welfare Abraham A. Ribicoff and Postmaster General J. Edward Day. Leonard W. Larson, M.D., president of the AMA, and Oliver Field, Director of the AMA Department of Investigation, spoke for organized medicine.

Others on the program included Herbert J. Miller, assistant U.S. attorney general in charge of the criminal division; George P. Larrick, commissioner of the FDA, and Paul Rand Dixon, chairman of the Federal Trade Commission.

Other speakers included representatives of the American Cancer Society, the Arthritis and Rheumatism Foundation, and the National Better Business Bureau.

C. Joseph Stetler, director of the Legal and Socio-Economic Division of the AMA, presided at the meeting.

Many state and county medical societies from throughout the nation sent representatives to the Congress. They carried back to their societies plans for cooperation with enforcement agencies at the local level and for a step-up of public education on the subject in an accelerated campaign against quacks.

HIGHLIGHTS OF THE TALKS

—Larson: "We must educate the public thoroughly and effectively. We must wage psychological as well as scientific warfare. We must not only prove the worthlessness of quackery, but we also must establish confidence in sound medical and health care.

"Speaking for the American Medical Association and our 180,000 physician-members, I pledge our efforts to the final eradication of quackery and all its minions and satraps."

—Ribicoff: "The total cost of unnecessary or dangerous medications in this country probably exceeds \$1 billion each year. Much of this

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MONTH IN WASHINGTON

Continued

expense is to men, women, and children who dearly need this money for good medical care or for other necessities of life.

"But quackery's costs in dollars only introduces the story. In terms of false hopes raised, in terms of ugly delusions fostered, in terms of tinkering with human life itself, the cost cannot be measured. The quack flirts with disaster. He challenges the sixth Commandment: 'Thou shalt not kill.'"

—Larrick: "The most widespread and expensive type of quackery in the United States today is in the promotion of vitamin products, special dietary foods and food supplements. Millions of consumers are being misled concerning their need for such products. Complicating this problem is a vast and growing 'folk-lore' or 'mythology' of nutrition which is being built up by pseudo-scientific literature in books, pamphlets and periodicals. As a result, millions of people are attempting self-medication for imaginary and real illnesses with a multitude of more or less irrational food items. Food quackery today can only be compared to the patent medicine craze which reached its height in the last century. Especially disturbing is the tendency shown by some big and hitherto respected food concerns to use quackery in their sales material."

—Dixon: "Properly drafted and administered, legislation giving the Federal Trade Commission power to issue temporary cease-and-desist orders would, while observing all the requirements of due process, make it possible to protect the public interest more adequately in many areas."

"Although in the case of food, drug, and cosmetic advertising, the Commission can . . . apply to district courts for temporary injunctions, it would be much more efficient for the Commission itself to issue temporary orders in those cases as well as in others."

—Day: "The peddling of fake medical cures is the most prominent fraudulent activity conducted through the U.S. mails today. This huge 'industry'—and it has grown to that extent—is so prevalent and so widespread that it taxes the manpower of the Postal Inspection Service to the utmost in trying to bring the perpetrators to justice."

"We are doing everything we can to make more of our inspectors available to work on cases of this nature, to the extent it will not jeopardize enforcement in other fields."

ADDITIONAL QUOTES

Dr. L. Henry Garland, American Cancer Society: "The charlatan is in business to make money and he does so by offering hope. He tends to be courteous, optimistic, easily understood by the laymen and confident that cure can be obtained. His patient does not care that the method used is a secret one, that the testimonials are largely fraudulent, or that the 'doctor' may not even be licensed. All he knows is that he is being reassured and treated by someone who seems to be interested in him as a person."

"If it is granted that the causes of charlatanism are . . . diverse, it seems obvious that control must be equally diverse—composed of the difficult and slow triad—public education, professional education and continued research into cancer prevention."

Continued on page 1620

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1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

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MONTH IN WASHINGTON

Continued from page 1616

—Dr. R. W. Lamont-Havers, Arthritis and Rheumatism Foundation: "That this is a large problem is indicated by the estimated 250 million dollars a year that arthritis victims spend upon unproven, and misrepresented products in a vain attempt to obtain unrealizable relief from their suffering. Not all of these products are quackery in the sense of being useless. Some contain active ingredients—usually salicylates, or apparatus such as vibrators, but are promoted with such misrepresentation of effects that the arthritic fully expects results beyond the capabilities of the drug. Others are outright quackery and include such popular items as alfalfa tea, uranium pads, honey and vinegar, etc. Of particular concern are the widely advertised so-called 'clinics,' chiefly in Missouri and Florida."

—Field: "We would like to envision the time when we can cease to worry about the medical quack. But it's going to take an awful lot of doing. The Food and Drug Administration, the Post Office Department, the Federal Trade Commission and the Food and Drug groups of many states of the Union, cannot do the job alone. It takes a program which seeks to acquaint the public with the problem, and swings into action quickly when there is a threat to the community or to the nation at large. This takes the help of all interested people—consumer groups, educational groups, religious organizations, and, most of all, those responsible for the education of the American youth. . . . The emphasis should be on letting the public know, strengthening the laws where necessary, but, most of all, providing a means of distinguishing between the legitimate medical practitioner and the one who pretends to be one."

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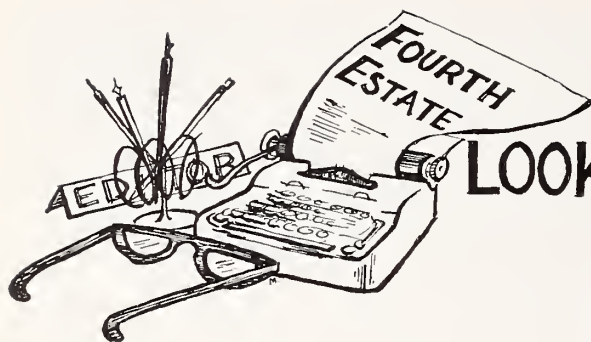
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Labeling Dangerous Substances

The stuff looked like strawberry pop, so the child drank it. Actually it was furniture polish and contained toxic ingredients.

In another instance, a 2-year-old drank dish-water detergent, and a slightly older youngster inhaled dangerous carbon tetrachloride while his mother cleaned a rug.

Years ago the medicine chest full of drugs was the big danger spot in the family household. But today peril for children—and adults as well—lurks in the pantry, the cleaning closet, the basement and the garage.

The hazardous materials are found in paint thinners and removers, cleansing agents, detergents and bleaches, lighter fluids, waxes and polishes and many similar products.

The Public Health Service says 600,000 children swallow such substances every year—and 500 die. Perhaps 900 adults die from like cause.

Last summer Congress enacted a new law designed to meet this much wider danger by requiring that products containing potentially harmful ingredients be strikingly labeled, with contents carefully noted and “antidote instructions” set down.

The old law dealing with poisons was far out of date. It mentioned just 12 substances. Food and Drug Administration officials estimate there are 250,000 to 300,000 hazardous materials on the market today, sold by some 8,000 companies.

Dozens of poison control centers around the country have done yeoman service, but often doctors found they could not act wisely to save a victim until they had first contacted a manufacturer to learn specifically what was in his product.

Recently Food and Drug authorities held

hearings on new regulations drafted pursuant to the 1960 law. A storm of opposition developed.

Some protesters said the rules went beyond the law's limits and were too stiff. Some feared that too many “danger” labels would weaken their cautionary effect. Others frankly argued that the “selling aspect” of labels would suffer in contrast.

Now the FDA says it will delay until Feb. 1, 1962, the effective date of regulations in this field. Spokesmen indicate the rules may be somewhat modified to take account of criticisms.

But consumer groups and poison control authorities are wisely urging that, whatever is done in response to just complaint, the government still insist on the bold, forceful and complete labeling of dangerous substances envisaged by the framers of a badly needed law.

Kokomo Tribune
Aug. 3, 1961

Foolish and Frenzied

By now a good many middle-aged American males who don't feel frenzied, frustrated or insecure must have about concluded that they are in the minority. The 40's and 50's are very trying years, they are frequently reminded, and if their unsettled feelings haven't made them aware of this they are abnormal.

It is all very disturbing. Nor did the convention of the American Medical Association in New York do anything to bring calm to those whose youth is behind them. Dr. John Briggs of St. Paul, Minn., told the convention that “for most of us” the 40's are “foolish” and the 50's “frenzied.”

We are in no position to argue with a medical man. But from our observation the 40's and 50's have no monopoly on frenzy or foolishness. We



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Up and Away...



Construction of the new ISMA Headquarters Building at 3935 North Meridian Street is progressing quickly. Members attending the annual convention attended a cornerstone-laying ceremony on Thursday, Oct. 26. The building is scheduled



for completion in the spring of 1962, at which time the headquarters offices will be moved from their present location in downtown Indianapolis.

have noted the tendency among teen-agers as well as those in their 20's and 30's. All this stress on psychotic and emotional disturbance points to a rather sick society, and we simply can't believe it's that sick. Though normal people may make less news, we suspect that the well adjusted continue in the majority. It would be reassuring to hear more about them.

Evansville Press
July 4, 1961

Extra Patience Pays Off

The snow which by now is slushy and unlamented brought out some of the best and worst in drivers of all kinds of vehicles. During the height of the storm and afterwards, the average driver got a chance to see examples of navigation on the streets and roads that ranged from the expert to the ridiculous.

Probably the most common fault among automobile drivers was the tendency to use too much power when there was too little traction for the wheels. At best this can result in an aggravating stall at an intersection, or some other equally awkward spot. At worse, too much power meant too much speed on icy surfaces, which led to accidents and deaths.

Although lecturing truck drivers on safety is a difficult task, the snow also brought out some unpleasantly dangerous habits from a few operators. The big tractor-trailer rigs can move

over slick highways with a good deal more certainty than the ordinary passenger vehicle. Knowing this, some truck drivers tended to set a pace on the highways that couldn't be matched with safety by the private automobile. Impatient truckers often roar around in a spray of ice, snow, mud and salt. This is nerve-wracking for the car driver, and can be potentially dangerous when the truck wheels fling the gooey mess off the road and onto the windshield of the car, temporarily blinding the driver.

More than at any other time, a snow storm proves that the key to highway safety is a combination of courtesy and common sense. This requires an extra measure of patience when traffic is slowed to a crawl, but such consideration brings greater safety for all during a time of extreme hazard on the highways.

Indianapolis Star
Dec. 18, 1960

A cannibal chief woke up one night writhing in pain. "Get the witch doctor," he ordered his wife. "Quick."

The medical man came promptly. "Well, of course, Chief, I can't make a proper diagnosis without a complete examination. But, for one thing, you've got a tic."

"Now, there, Motsumoolo," the chief's wife spoke up, in some triumph. "That'll teach you to gulp your meals in such a hurry. I told you to take that missionary's wristwatch off."—*Wall Street Journal*, July 5, 1960.

Infections Caused by *Pseudomonas Aeruginosa*

Twenty-eight cases of infections caused by *Pseudomonas aeruginosa* are reported. This disease is more prevalent in infants and children and in debilitated adults. Even though this organism is often classed as a non-pathogen, infections caused by *Pseudomonas aeruginosa* are quite serious. The different manifestations and clinical pictures are summarized. The incidence of *Pseudomonas* as the etiologic agent in solitary perforation of the bowel is emphasized. Indiscriminate therapy with antibiotics seems to enhance the pathogenicity of *Pseudomonas aeruginosa*. The relationship of steroids to infections and the possible masking of the disease state is a point of importance.

A. WENDELL MUSSER, M.D.*

PARKER R. BEAMER, Ph.D., M.D.†

USE OF ANTIBIOTICS in clinical medicine has led to a great many changes in the practice of medicine. Much good has been derived from the use of these medications. On the other hand, as with all good things, some harm has also resulted, whether it be intrinsic or iatrogenic. Owing to these factors and many others, which will be discussed later, *Pseudomonas aeruginosa* has become more prevalent as a definitely pathogenic and virulent micro-organism. One of us has recently studied experimentally the pathogenicity of *P. aeruginosa*¹, and we were then

stimulated to study our files in order to acquire information pertaining to (1) the number of cases, (2) the primary disease, (3) the estimated duration of infection, (4) the extent of lesions, (5) the ages, sex and race of the patients, and (6) the white blood cell count at the height of infection.

During a 6-year period, from September 1954 to September 1960, 2,603 autopsies were performed in our institution. Twenty-eight proved cases of *Pseudomonas* infection were found, i.e., examples of this condition in which cultures yielded growth of *P. aeruginosa*, and the distinctive lesions were identified in the tissue from which the material for cultures was collected. A representative case is outlined in detail in order to exemplify some of the findings in a fatal *Pseudomonas* infection, and the other 27 are summarized in Table I.

† From the Department of Pathology, Indiana University School of Medicine.

* Clinical Fellow of the National Cancer Institute, formerly from the Department of Pathology, Indiana University School of Medicine; now at Womack Army Hospital, Fort Bragg, N. C.

Case Report

Clinical findings. The patient (I.U.M.C. Autopsy No. 9323) was a 4-month-old white male infant, who was admitted to the hospital at the Indiana University Medical Center with the chief findings of fever in association with sores on his buttocks. The infant was well until one week prior to admittance, at which time he developed what was described as a "cold." The patient was febrile and was treated with penicillin, which did not result in any noticeable improvement. The fever persisted, and two days prior to admittance, the patient became jaundiced and developed blisters on his buttocks, which were subsequently indurated and blue. Other blisters became apparent in the skin of the groin, heel, and abdomen. After the development of these lesions, the patient was referred to the Indiana University Medical Center for diagnosis and therapy.

Upon arrival at the hospital, the boy's temperature was 101° F., the pulse 120 per minute, and respirations 40 per minute, with an associated expiratory grunt. The scleras were icteric, but examination of the nose and throat revealed no significant findings. Scattered rhonchi were heard throughout the lungs. The liver was palpable 2 cm below the left costal margin, and the spleen 3 cm below the right margin. In addition to the extreme jaundice, bullous lesions (1 x 1 cm) on an erythematous base were present in both groins. Slightly elevated purpuric lesions were observed in the skin of the left anterior region of the abdomen and the left heel. The perianal and perineal areas were indurated, with the formation of eschar, and a peripheral purple discoloration was present. The clinical impression at the time of admittance was "sepsis", bronchopneumonia, and gangrene of the skin following infection.

Urinalysis revealed a heavy trace of albumin, a specific gravity of 1.015, and 4-plus bilirubin. Other pertinent laboratory studies were as follows: hemoglobin 7.8 gm per 100 ml.; nonprotein nitrogen 39 mg per 100 ml; total proteins 4.67 gms per 100 ml; white blood cell count 5500 per cu mm, with a conspicuous shift to the left. A culture of the blood yielded growth of *Pseudomonas aeruginosa*, but no growth was observed in a culture of material aspirated from the peritoneal cavity. Examination of roentgenograms of the chest revealed evidence of bronchopneu-

monia, and findings in a film of the abdomen indicated a dilatation of the small and large bowel, thought to represent a paralytic ileus. Subsequent films indicated a persistence of the distention of the small and large bowel.

The patient's physical condition remained critical and his course was gradually ingravescent. The infant was immediately treated with intravenous fluids, chloramphenicol, and erythromycin. Administration of the antibiotics was continued for five days, at which time the erythromycin was discontinued, and combined therapy with terramycin and chloramphenicol was begun. The patient died nine days after admission.

Pathologic Findings

An intense degree of generalized jaundice was present, and necrotic and crusted lesions of the skin of the buttocks, left heel, nose, perioral area, abdomen, and inguinal region were observed. Histologic studies revealed relatively large foci of coagulative necrosis, often associ-

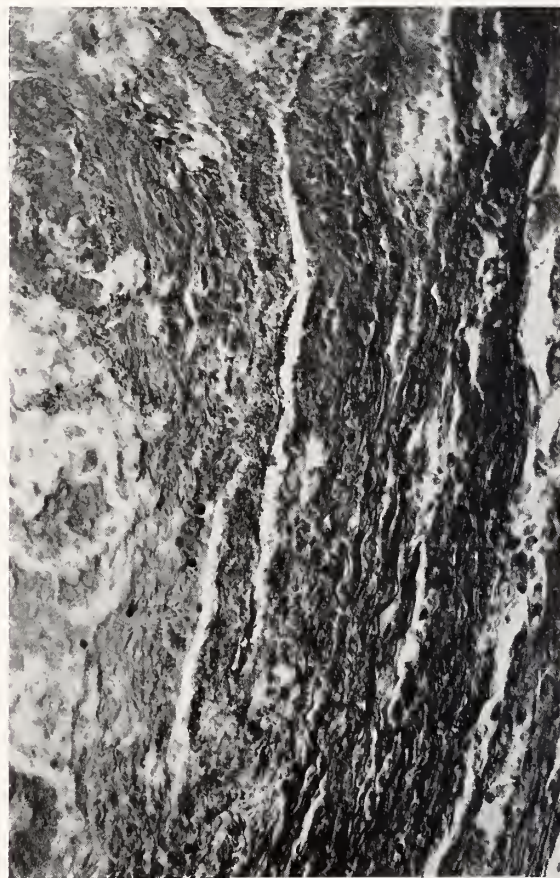


FIGURE 1

NOTE ADVANCED necrosis of all layers of the appendix. (Hematoxylin and eosin, X 300).

ated with ulceration of the epithelium. Leukocytes were present in the superficial exudate, but only few were directly associated with the necrotic areas. Gram-negative rods were numerous about and in the walls of blood vessels, as well as dispersed in the connective tissue of the dermis.

The peritoneum was dull and covered by a shaggy membrane that was composed chiefly of fibrin, and approximately 300 ml of dark orange, turbid fluid were collected from the peritoneal cavity. Cultures of the material in the peritoneal cavity yielded growth of *P. aeruginosa* (predominantly), and this finding was confirmed by the results of postmortem blood culture. A few colonies of *Staphylococcus aureus* and *Escherichia coli* were also cultured from the specimen of peritoneal fluid.

The cecum, appendix, and portions of the jejunum and ileum were incorporated into a mass by means of green fibrinous exudate. The bowel was hemorrhagic and friable, and a 1-cm per-

foration of the cecum was present 2 cm proximal to the orifice of the appendix. Microscopically, fairly advanced coagulative necrosis of the appendix (Figure 1) and the cecum were observed, and the site of perforation was related to one of these lesions. Gram-negative rods were present in many foci of the coagulative necrosis.

Focal and diffuse regions of coagulative necrosis were found in the lungs (Figures 2 and 3), liver (Figures 4 and 5), lymph nodes, adrenal glands, retroperitoneal connective tissue, and pancreas. All of the lesions contained Gram-negative rods, many times in association with blood vessels, and such vessels frequently contained thrombi. *P. aeruginosa* was cultured from the lungs and liver.

In addition to the preceding findings, there was atrophy of the thymus and some of the lymph nodes. Only little or no proliferation of connective tissue or capillaries was observed in relation to the inflammatory process, and a slight



FIGURE 2

AREAS OF HEMORRHAGE and necrosis in the lung are seen as focal dark discoloration.

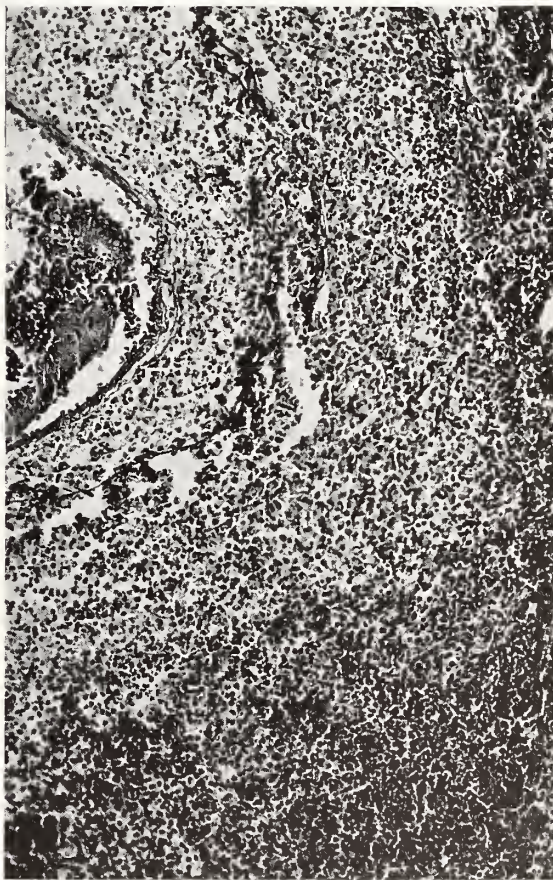


FIGURE 3

THROMBOSIS of a vessel in the lung associated with necrosis and hemorrhage of the surrounding lung tissue. (Hematoxylin and eosin, X 150).



FIGURE 4

FOCAL AND DIFFUSE areas of necrosis are noted in the liver.

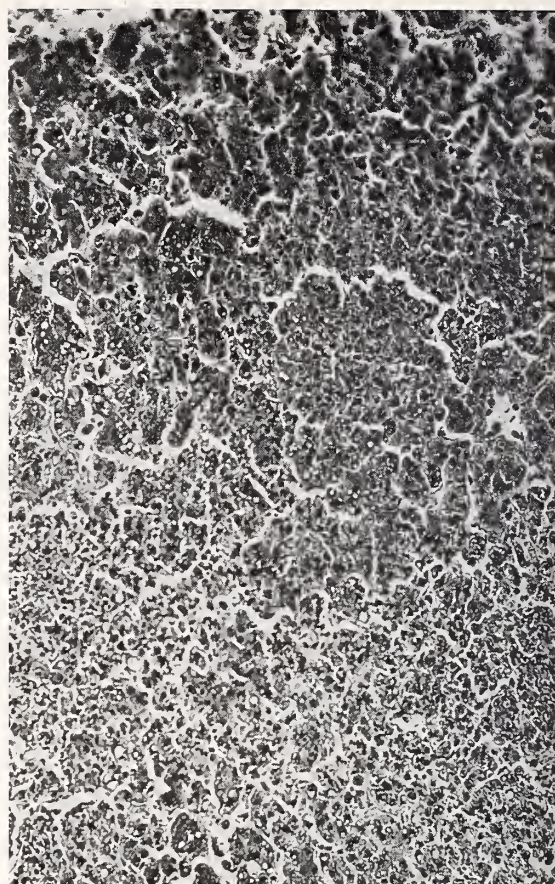


FIGURE 5

IRREGULAR AREAS of necrosis of liver cells are noted. (Hematoxylin and eosin, X 150).

myelocytic hyperplasia of the bone marrow was noted.

Comment

According to the description in Bergey's Manual,² *Pseudomonas aeruginosa* is primarily a plant pathogen, rather than an animal pathogen, but many reports of *Pseudomonas* infection may be found in the pertinent medical literature.^{3,4,5,6,7,8} Gessard⁹ first isolated the organism from an infection in 1882, and Fraenkel's¹⁰ description in 1917 was the first really concise resume of the lesions caused by this truly pathogenic organism.

In the 28 cases of the series summarized in this paper, the ages of the patients ranged from 3 days to 75 years, and Stanley¹¹ and others have emphasized the fact that most *Pseudomonas* infections occur in infants, children and debilitated adults.^{12,13,14} Five of the patients had involvement of the skin, and the disease of the skin has been called ecthyma gangrenosum, ac-

cording to the original description of Ehlers.¹⁵ The coagulative necrosis of the skin is quite characteristic. The skin has been regarded by some as the portal of entry for *Pseudomonas* organisms, but there is good evidence to support the view that the skin may be secondarily involved by means of the hematogenous route.

Solitary perforation of the bowel in *Pseudomonas* infection is not unusual, and this incident is frequently the basis for the development of an overwhelming peritonitis and septicemia.¹⁶ The perforation occurs as a result of primary disease of the bowel. Characteristic lesions have been observed in various sites throughout the gastrointestinal tract, but none have been known to occur in the esophagus. Lesions of the esophagus were found in patients in this series, but they were apparently secondary to trauma occurring with surgery. Gastrointestinal lesions may be diffuse, typhoid-like, or focal, and in the diffuse type, ulcerations may occur without evidence of healing. The lymphoid tissue of the

bowel is not the initial site of the lesions. The stomach and intestine may be involved by means of (1) the hematogenous route, (2) ingestion of the organism, and (3) bile from an infected gall bladder. It is interesting to note that one of the patients in this series had a characteristic lesion in the gall bladder, but unfortunately, no material was collected for culture.

Infections in the central nervous system of children less than two years of age are caused chiefly by the Enterobacteriaceae, and some by *P. aeruginosa*.^{17,18} All three of the patients in this category had an unusually destructive ventriculitis, one example of which was apparently secondary to a myelomeningocele.

The pathogenicity of *P. aeruginosa* seems to be enhanced by prolonged and indiscriminate therapy with antibiotics.^{19,20} The antibiotics usually administered in the hospitals of Indiana University Medical Center are listed in Table I. There is no reliable means of acquiring dependable information with regard to antibiotic therapy outside of the hospital. The prophylactic use of broad-spectrum antibiotics seems to have led to an increased incidence of *Pseudomonas* infections. It is thought that the antibiotics, most of which are not effectively bactericidal for *Pseudomonas*, cause death of the other competing bacteria, thereby resulting in a clear, noncompetitive environment for growth of the *Pseudomonas*. A similar situation is apparently true in the instance of *Candida albicans*.

Woods and Manning²¹ reported 25 cases of clinical moniliasis recognized after the therapeutic use of penicillin, chlortetracycline, and chloramphenicol. *In vitro* studies of four strains of *Candida* revealed that these antibiotics have no stimulating or suppressing effect on the rate of growth. Suppression of bacterial flora coexisting with *Candida*, and competing for nutrition in the same substrate, is probably the reason for the unusual growth of *Candida*. Inasmuch as the severity of the *Pseudomonas* infection in the four patients in this category was so great, it is difficult to evaluate the *Candida* on any basis other than a secondary invader. This same situation may also attain with reference to the relation of staphylococcal²² and *Pseudomonas* infections.

Several of the patients were treated with steroid drugs of some sort. It is difficult to relate the effect of these drugs in diseases that, for the most part, manifest such a relatively rapid

course. Administration of ACTH or cortisone to patients with acute febrile illness, or with illness characterized by malaise, anorexia and evidence of generalized toxicity, frequently leads to prompt defervescence and amelioration of these symptoms. In infections with less prominent symptoms, these effects of the hormones are less striking, or they may be lacking. Despite the relatively asymptomatic and afebrile state that frequently follows the administration of adrenocortical hormones, bacteriologic findings indicate (1) no apparent improvement or even (2) definite impairment in the capacity of the patient to dispose of the offending agent. Bacteremia may develop or persist, bacterial counts in exudates or affected tissues may be increased, and the bacteria may become disseminated, even in the absence of clinical evidence of such adverse effects. Production of antibody is neither accelerated nor suppressed, with doses ordinarily used clinically. Complications of the infections may occur, although their presence may be marked by the administration of ACTH or cortisone.²³

Pseudomonas infections are complex; and their existence, duration, and mortality depends upon many factors. According to Beamer,²⁴ "the duration of the inflammatory reaction (and the resulting lesion) is regulated by several factors, among which the following are probably chief in importance: (1) the initial dose and portal of entry of the injuring agent; (2) the type of damage resulting from the direct effect of the injuring agent; (3) the persistence, or the effective removal of the injuring agent; (4) the capacity of the host's tissues to react; and (5) intervention with drugs, biologic preparations, surgical procedures and other means of modifying the natural course of the inflammation."

Summary

This paper deals with the clinicopathologic findings in 28 patients with *Pseudomonas* infection, from a total of 2603 autopsies performed during a six-year period. One of the cases, that of a four-month-old white boy, is described in detail as a representative example of the widespread coagulative necrosis, with little or no cellular inflammatory reaction. Multiple aspects of *Pseudomonas* infections, including age incidence, inciting agents, sites of involvement, portals of entry, antibiotic therapy as a probable cause, and treatment with steroid drug are discussed.

TABLE I
SUMMARY OF CASES

CASE	CULTURES	WBC	POSTMORTEM BLOOD CULTURE	PRIMARY DISEASE
18 yr. WM	Lung: <i>Pseudomonas</i> Staph. aureus	19,100	B-hemolytic Strep.	Acute lymphocytic leukemia
12 do. WM	None taken	11,350	<i>Ps. aeruginosa</i>	Cong. Ht. Disease, Tetralogy of Fallot
8 do. WF	Lung: <i>pseudomonas</i>	17,850	<i>Pr. vulgaris</i> and γ -Strep.	Repair of T-E fistula 4 days before death
4 mo. WM	Bronchus: <i>E. coli</i> , γ -Strep., <i>Pseudomonas</i> Lung: Same plus α -Strep. Brain: same plus B-Strep.	5,600	<i>Aerobacter aerogenes</i> α -Strep. <i>Pseudomonas</i>	Giant cell pneumonia (exposure to chicken-pox)
17 mo. CF	Sp. Fl.: <i>Pseudomonas</i> Lung: Staph. aureus <i>Pseudomonas</i>	9,400	<i>Pseudomonas</i>	Internal hydrocephalus
3 do. CF	Lung: <i>Pseudomonas</i>	40,000	<i>Pseudomonas</i>	<i>Pseudomonas</i> septicemia
5 mo. WM	Skin: <i>Pseudomonas</i>	3,100	<i>Pseudomonas</i>	<i>Pseudomonas</i> cellulitis and septicemia
1 wk. WF	<i>Pseudomonas</i> in oral cavity, plural cavities, and lung <i>Candida</i> in medi- astinum	20,100	<i>Pseudomonas</i>	T-E fistula and Cong. Ht. Disease
6 da. WM	Lung: <i>Pseudomonas</i> Nose & Throat: Staph. aureus	27,000	Staph. aureus	Bronchopneumonia
75 yr. WM	Lung: <i>pseudomonas</i>	.....	<i>Pseudomonas</i>	Myasthenia gravis ASHD Chr. duodenal ulcer
50 yr. WM	None taken	11,800	<i>Pseudomonas</i>	Perf. duodenal ulcer
4 mo. WM	Brain, meninges, Sp. Fl.: <i>Pseudomonas</i>	15,450	.....	Myelomeningocele with meningitis
17 da. WF	Peritoneum and Lung: <i>Klebsiella</i> , <i>Pseudomonas</i> , and B-Strep.	20,100	<i>Pseudomonas</i> B-Strep.	Perforated colon
6 mo. WM	Brain: <i>Pseudomonas</i> Lung: <i>Candida</i>	19,600	.....	Hydrocephalus
6 mo. WM	Thigh: α -Strep., <i>Pseudomonas</i> Sup. Sag. Sinus: <i>Pseudomonas</i> Calan: <i>Ps.</i> and <i>E. coli</i>	Died Suddenly	.....	Ecthyma gangrenosum
12 yr. WF	Peritoneum: <i>Pseudomonas</i> Kidneys: <i>Candida</i>	.....	Staph. aureus and <i>Pseudomonas</i>	Aplastic anemia
57 yr. WF	.....	19,200	<i>Pseudomonas</i>	30-35% third degree burn
2 mo. WM	Abd. cavity and Cecum: <i>Pr. vulgaris</i> Appendix: <i>Pseudomonas</i>	12,700	.....	Perforated trans. colon Ecthyma gangrenosum
9 wk. WF	Meninges: <i>Pseudomonas</i> and a few Staph. aureus	14,600	Negative	Acute purulent meningitis
30 yr. CF	Cecum and peritoneum: <i>Ps.</i>	14,400	.....	Necrotizing calitis
10 da. WM	Skin: <i>Pseudomonas</i>	.....	<i>Pseudomonas</i>	Immaturity with ecthyma gangrenosum
30 yr. CF	Cervix: <i>Pseudomonas</i> Ascitic Fl.: <i>Pseudomonas</i>	5,500	<i>Pseudomonas</i>	Mercury Poisoning
1 wk. WF	Stool: <i>Aerobacter</i> and <i>Ps.</i> Mediastinum: <i>Aerobacter</i> Ulcer of Calan: <i>Aerobacter</i> and <i>Pseudomonas</i>	3,100	<i>Pseudomonas</i>	T-E fistula Ecthyma gangrenosum
17 do. WF	Pleural Cavity: <i>Ps.</i> & Staph. Lung: <i>Ps.</i> and Staph. Nose & Throat: <i>Pseudomonas</i>	7,525	.....	T-E fistula Cong. Ht. Dis.
13 da. WM	.....	18,050	<i>Pseudomonas</i>	T-E fistula Vent. septal defect of heart
8 yr. WF	Nose: <i>Ps.</i> , B-Strep. Larynx: <i>Ps.</i> , B-Strep. and <i>Candida</i> Mouth: <i>Candida</i> , <i>Ps.</i> , B-Strep. Ascitic Fl.: <i>Pseudomonas</i> Vagina: γ -Strep., <i>Ps.</i> , <i>E. coli</i> , and <i>Aerobacter</i>	3040- 900	<i>Pseudomonas</i>	Agonulocytosis Ecthyma gangrenosum
70 yr. WF	Peritoneal Fl.: <i>Ps.</i> and <i>Aerobacter</i> Appendix: <i>Ps.</i> & <i>Aerobacter</i>	13,860	.....	Monocytic leukemia

HOURS PM	EXTENT OF LESIONS	MEDICATIONS	EST. DURATION OF INFECTION
2½	Hemorrhagic bronchopneumonia with focal areas of coag. necrosis	Aminopterin; Purinethol Cortisone	2 mos.
5	Hemorrhagic bronchopneumonia	Oxygen	3 days
7	Hemorrhagic necrotizing bronchopneumonia	Oxygen	5 days
1½	Acute ulcerations of ileum and colon with coag. necrosis and thrombosis of vessels	Bicillin, Streptomycin Aminophyllin; Achromycin	7 weeks
3	Confluent bronchopneumonia with abscesses and focal areas of coag. necrosis	Penicillin; Achromycin Penicillin; Streptomycin	4 weeks
3	Coag. necrosis in liver, spleen, lungs, kidneys, and gastric mucosa	Oxygen; Vitamin K	3 days
7	Coag. necrosis of skin of abdominal wall and thigh. Coag. necrosis of lungs and pons	Penicillin; Pyrilamine Dramonine; Ilotycin Hydracortisone	8 days
3	Coag. necrosis of tongue, skin, parietal pleura, esophagus, lungs	Penicillin	4 days
6	Bronchopneumonia with focal areas of coag. necrosis	Penicillin	3 days
3	Confluent bronchopneumonia with abscesses and focal coag. necrosis	.....	? Died 3 hrs. after hospitalization
3	Bronchopneumonia with focal areas of coag. necrosis	Achromycin	1-2 days
1	Acute meningitis and ventriculitis with coag. necrosis	Furacin oint.; Penicillin Streptomycin; Chloramycetin	16 days
4	Peritonitis, coag. necrosis of lungs, gangrene of bowel	Penicillin; Streptomycin	6 days
n.l.	Pseudomembranous ventriculitis	Achromycin	16 days
4	Necrosis with ulceration of skin of thigh and perineal region Pseudomembranous colitis with coag. necrosis	Penicillin	34 days
2	Peritonitis and focal necrosis of kidneys	Penicillin; Achramycin Cortisone	2 days
3	Coag. necrosis of skin; acute nephrosis; acute focal necrotizing colitis with thrombi in veins	Blood transfusions	1 day
5	Peritonitis, coag. necrosis of colon, appendix, lungs, and skin; thrombi in pulmonary and mesenteric veins	Penicillin; Streptomycin Achramycin	53 days
n.l.	Meningitis with ventriculitis	.....	8 days
6	Peritonitis with coag. necrosis of cecum	Achromycin	14 days
n.l.	Hemorrhagic bronchopneumonia	Penicillin	2 days
3½	Coag. necrosis of vagina, lungs, gall bladder, and lymph nodes. Peritonitis	Penicillin; Streptomycin Chloromycetin	12 days
5	Coag. necrosis of esophagus, duod., lungs, skin, myocardium, and colon	Penicillin; Streptomycin Polymyxin; Bacitracin Oint.	2 days
n.l.	Empyema, rt. pleural cavity. Bronchopneumonia with coag. necrosis	Penicillin; Streptomycin Achramycin	17 days
n.l.	Coag. necrosis of gall bladder and lungs	Achromycin; Penicillin Streptomycin	5 days
3	Coag. necrosis of serosa and myometrium of uterus, vagina, stomach, jejunum, colon, lung, tonsil, mucosa of trachea	Achramycin; Penicillin Kynex	16 days
n.l.	Coag. necrosis of stomach, cecum, colon, appendix with thrombi in veins	Purinethol; Meticorten Penicillin; Streptomycin	3-16 days

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Intralesional Administration Of Triamcinolone Acetonide In Dermatological Disorders

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MANY INFLAMMATORY dermatological conditions are known to respond to treatment with corticosteroids.¹⁻¹¹ The corticosteroid is usually effective when given orally⁹⁻¹¹ and, in many instances, when administered topically.¹⁻⁸ Not infrequently, however, the amount of the agent which must be given by the systemic route in order to elicit a favorable response in local cutaneous lesions is so large that side-effects could become a problem,¹² particularly if treatment had to be continued for a long time.

When topical treatment of cutaneous lesions fails to produce the desired improvement, then it would seem logical to introduce the corticosteroid intralesionally—that is, directly by injection into the affected area—so as to develop the greatest possible *local* concentration of the anti-inflammatory agent at the site where it is needed. Abundant evidence for the local inflammatory effect of injected corticosteroids has been accumulated over a number of years in the treatment of arthritis by injection of the steroids intraarticularly.¹³⁻¹⁸ A number of reports have already appeared describing the successful treatment of skin lesions by local injections of corticosteroids.¹⁹⁻²²

The study about to be presented involved 24 patients with common dermatologic problems. All were treated with triamcinolone acetonide* supplied as a suspension, containing 10 mg of the agent per cubic centimeter. As will be seen,

an excellent result was seen in practically all of the patients of the series.

Materials and Methods

Patients—The 24 patients in the study group were seen by the author in his office of practice of dermatology. The group included 9 cases of localized neurodermatitis, 8 cases of psoriasis, 3 of prurigo nodularis, and 2 each of alopecia areata and eczema.

Medication and Its Administration—Triamcinolone acetonide suspension (10 mg/cc) was administered intradermally directly into lesions, often at several sites, through a 24-gauge needle. Total dosage at one treatment never exceeded one cubic centimeter of suspension and this was usually repeated at intervals of two weeks as long as required. Generally, from one to six injections were sufficient to induce a good response, with complete healing of the cutaneous lesion.

Results

Of the 24 patients treated with triamcinolone acetonide intralesionally, 20 manifested an "excellent" response, itching being relieved at once and the lesions promptly disappearing. Three patients had a "good" response, itching being relieved but lesions clearing more gradually than in those with an "excellent" response, with fresh lesions later appearing. One patient had only a "fair" response, the itching being only partially relieved and lesions persisting with comparatively little improvement, if any at all.

The most impressive response was seen in the eight patients with psoriasis. Even after only one

* Supplied as Kenalog® Parenteral by Dr. John T. Groel of the Squibb Institute for Medical Research, New Brunswick, N. J.

or two injections, lesions disappeared entirely from some patients. The response of all the patients with psoriasis was considered excellent. An excellent response occurred also in all of the three patients with prurigo nodularis and in two with eczema of the hands or fingers.

Six of the nine patients with localized neurodermatitis likewise had an "excellent" response, but, of the remaining three, only a "fair" response occurred in one with scalp lesions and loss of hair and a good response in the other two. Re-growth of hair occurred in two patients with alopecia areata within two months after injections were started, the response being considered "excellent" in one and "good" in the other.

Side Effects

No evidence of toxicity was seen in any patient. In several individuals—each of whom experienced an "excellent" response—the skin of the injected area became mildly atrophic. This atrophy or thinning of the skin became less marked after several months and has been of small cosmetic concern to the patients. One of these patients developed a severe pustular acne on the forehead which was considered a reaction

to the steroid. There were no other undesirable responses which could be attributed to the medication.

Discussion

The patients included in this investigation received no orally administered corticosteroid, although a considerable number of them were treated concomitantly with a topical corticosteroid formulation. In some instances triamcinolone acetanide was applied as an ointment or cream either previously or at the same time that this agent was being employed by intralesional injection. Most of the patients with psoriasis were treated concurrently with a tar lotion. It is not, therefore, possible to ascribe all of the benefit observed in the 24 patients of this report exclusively to the intralesional injection of triamcinolone acetanide.

When it is appreciated, however, that the conditions treated had existed for several years (see Table I) in most patients and had cleared completely after only a few intralesional injections of the corticosteroid, the role of this agent, when administered directly into cutaneous lesions, must be considered as decisive.

In the present study, the intralesional injection

TABLE I
RESULTS OF INTRALESIONAL INJECTION OF TRIAMCINOLONE ACETONIDE
IN DERMATOLOGIC DISORDERS

Diagnosis	Duration	No. of Patients	RESULTS*			Comment
			Excellent	Good	Fair	
Neurodermatitis Localized	1 to 10 years	9	6	2	1	Fair response seen in patient with scalp lesions. Others had lesions chiefly on extremities.
Psoriasis	3 mos. to 20 yrs.	8	8			All lesions disappeared, in 1 case after a single injection; lesions on extremities, face, buttocks.
Prurigo Nodularis	2 to 7 years	3	3			Marked improvement or clearance after 1 or 2 injections. Lesions on extremities.
Alopecia Areata	6 mos.	2	1	1		Hair regrowth in both cases within 2 months.
Eczema	2 yrs.	2	2			Lesions on hands disappeared after 1 or 2 injections.
TOTALS		24	20	3	1	

* Excellent: Prompt relief of itching and disappearance of lesions.

Good: Improvement noted in lesions with relief of itching but new lesions appeared.

Fair: Lesions persisted and itching only partially relieved.

tion of triamcinolone acetonide was notably free of side reactions. Small dosages required in order to obtain a high concentration of corticosteroid in the lesion would indicate unusual promise for the described use of triamcinolone acetonide in dermatologic disorders.

Summary

Twenty-four patients with various dermatologic conditions were treated by the intralesional injection of triamcinolone acetonide (usually 1 cc every 2 weeks). Twenty of the group manifested an "excellent" response to therapy, with prompt relief of itching and disappearance of lesions; three a "good" response with improvement noted in lesions and with itching relieved but with new lesions appearing; and one a "fair" response, with lesions persisting and itching only partially relieved.

All of the eight patients with psoriasis experienced clearing of their lesions, usually after only very few injections, as did three patients with prurigo nodularis, two with eczema, one with alopecia areata, and six with localized neurodermatitis. The "good" responses were recorded in two patients with neurodermatitis and one with alopecia areata. The single "fair" response occurred in a patient with neurodermatitis.

Side effects were remarkably few and did not constitute a problem.

It is concluded that the intralesional administration of triamcinolone acetonide can be recommended for the treatment of inflammatory dermatoses, being highly effective in clearing lesions without the hazards that often attend the use of orally administered corticosteroids.

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Report of a Case

Benign Superior Vena Caval Obstruction

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According to Bindelglass and Trubowitz, Hase first recognized the entity of vascular occlusion by fibrous mediastinitis in 1889. Sclerosing mediastinitis has been discussed by a number of authors.^{4, 5, 7, 8, 9, 10, 11, 18} The incidence of chronic mediastinitis in a series of cases of superior vena caval obstruction was reported as approximately 25% by McIntyre and Sykes.¹⁰ Recently a patient with sclerosing mediastinitis and superior vena caval obstruction presented himself for treatment at the Indianapolis Veterans Administration Hospital. This report is a presentation of his case and a survey of the problem.

Case Report

A 31-YEAR-OLD white male janitor was admitted on March 29, 1960 with the chief complaint of "choking off" for two months. He had noticed a progressively increasing sense of fullness in his head and neck that was made worse by bending over and was relieved by assuming the erect position. This feeling was also present when in bed at night. He was unaware of any enlargement of his face or neck, nor had he noticed any prominent veins of the upper half of his body. There was no history of previous pulmonary disease or symptoms. He was never exposed to tuberculosis as far as he knew. He had had excision of a pilonidal sinus in 1956. A chest x-ray at that time revealed "calcified nodes" in the right hilum. (Figure 1)

Physical examination showed distended veins of the neck and upper thorax. The face was dusky. There was minimal engorgement of retinal veins. Other than these positive findings, his physical examination was not remarkable.

Routine urinalysis and hemogram were normal.

The serologic test for syphilis was negative. Skin tests for tuberculosis were negative through the second strength PPD. Histoplasmin skin test was positive. Venous pressure in the right arm was 18 cm of water; the left arm venous pressure was 19 cm of water. Bronchoscopy revealed a normal endobronchial tree.

Roentgenographic examination of the chest revealed an upper right mediastinal tumor with calcification. (Figures 2, 3, 4) This had increased in size since his previous chest x-ray at this institution in 1956. (Figure 1) An angiocardio-gram revealed almost complete obstruction of the superior vena cava. (Figure 5)

On April 25, the patient underwent exploratory mediastinotomy. At that time a large fibrotic densely adherent mass was found in the upper right mediastinum constricting the superior vena cava. Performance of a bypass procedure was thought impossible because of involvement of the innominate and subclavian veins as well as the superior vena cava. A large portion of the mass was removed in an attempt to decompress the superior vena cava. The wall of the vena cava was markedly thickened and rigid, however, and little or no improvement was

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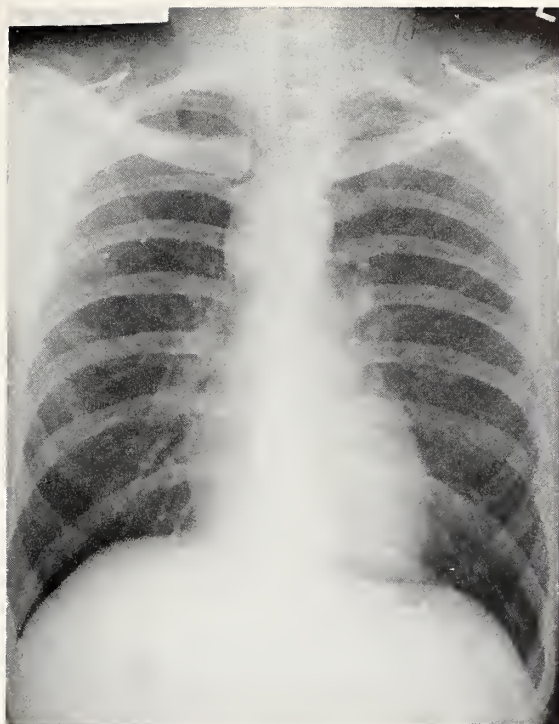


FIGURE 1
CHEST X-RAY 1956: Patient was asymptomatic.

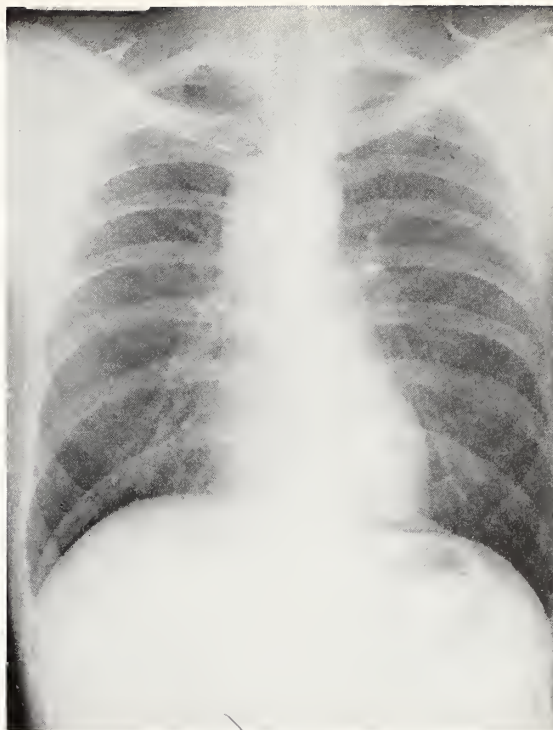


FIGURE 2
CHEST X-RAY 1960: Patient had symptoms of superior vena caval obstruction.

effected. The patient's postoperative course was relatively benign and he was discharged unchanged on the fourteenth postoperative day. The postoperative venous pressure was 17.5 cm of water in the right arm and 19 cm of water in the left arm. He has been observed for ten months with no change in physical findings or symptoms.

Pathologic Examination

Grossly the resected tissue was resilient and pale gray. In some areas it was almost cartilaginous. Microscopically, it consisted primarily of dense collagenous connective tissue within which there were remnants of lymph nodes and some portions of thymus. The lymph nodal and thymic parenchyma were not abnormal. The capsule of a lymph node could be seen to blend with the abundant surrounding connective tissue. This connective tissue was characterized by dense, thick bundles of collagen with numerous fibroblasts and scattered inflammatory cells. They were chiefly neutrophils, but some lymphocytes and occasional eosinophils also were encountered. The amount of connective tissue was rather great. In most areas the fibrocytes were well developed but in others they were of the



FIGURE 3
PLANOGRAM of calcific density, coronal plane.

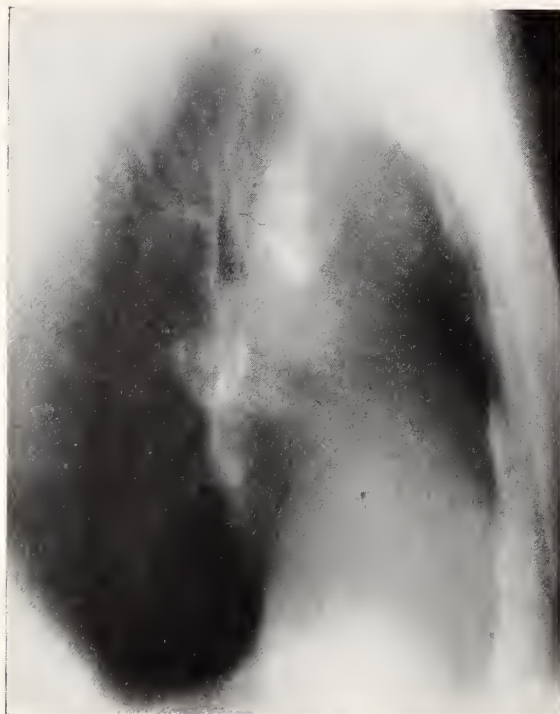


FIGURE 4
PLANOGRAM of calcific density, sagittal plane.

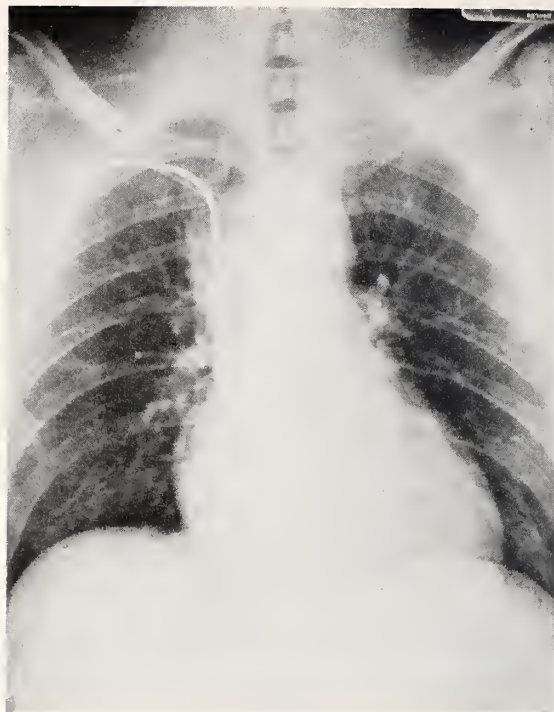


FIGURE 5
VENOGRAM. The catheter has been passed into the obstructed segment. The contrast medium injection demonstrates the area of most marked narrowing with the normal sized vena cava below.

fibroblastic variety and appeared young. Occasional bizarre nuclei were seen in the fibrocytes, but no mitotic figures were found. No granulomata were seen. No evidence of lymphoma or other neoplasm was seen. No organisms were recognized. The appearance was that of a nonspecific inflammatory reaction with a marked amount of fibrosis.

Discussion

McIntyre and Sykes divided the etiology of chronic fibrous mediastinitis among tuberculosis, syphilis and the idiopathic variety relatively evenly, although there was a slightly greater percentage of those with luetic etiology.¹⁰ They stated that cases of tuberculous and luetic origin were decreasing and those of idiopathic origin were increasing. More recently, histoplasmosis has been thought to produce this entity.¹¹ Recurrent pulmonary infections, tularemia, brucellosis, trauma, and "cat-scratch fever" are thought to be other causes.

At the present time there are probably two great groups of so-called "benign" diseases causing superior vena caval obstruction. One is due to granulomatous disease, most often tuber-

culosis. Of late, we have come to realize that histoplasmosis plays an important role, especially in those regions where this disease is endemic. Grossly, this lesion is indistinguishable from idiopathic sclerosing mediastinitis, the causative agent in the second group. Dense scarring and calcification are common to both. Microscopically, however, there is usually evidence of lymph node involvement with granulomatous change with giant cells and epithelioid cells and occasionally caseation.

In contrast, idiopathic sclerosing mediastinitis, usually has little or no recognizable lymphoid tissue present. Grossly, this appears as a mass of firmly fixed fibrous tissue in the mediastinum. Although it is not invasive, it lacks a capsule. Dense scar tissue envelopes and fixes all the mediastinal structures that pass through it. The walls of the included vessels become thickened and densely scarred and are virtually inseparable from the enveloping mass. Microscopically, it is composed primarily of bundles of dense collagen with some fibroblastic activity, with atypical nuclei but with little or no mitotic activity. Calcified foci may occur. Inflammatory cells are present. They are usually lymphocytes,

plasma cells and eosinophils, but neutrophils may be present. The typical granulomatous process is absent. Whether this represents a nongranulomatous response with complete lymph node replacement and scarring is a matter of conjecture. The resemblance of sclerosing mediastinitis and sclerosing retroperitonitis has been noted.⁸

Produces Biphasic Syndrome

Regardless of its etiology and whether this disease entity be termed sclerosing mediastinitis, chronic fibrous mediastinitis or mediastinal granuloma, it produces a biphasic syndrome. The less impressive early phase is that of an asymptomatic mediastinal tumor which is found on routine chest roentgenogram. The picture is usually one of a right superior mediastinal mass usually associated with intramural calcification. It is at this point that the mass should be removed in order to prevent further difficulty.¹

The more commonly described and frustratingly difficult syndrome from the standpoint of treatment results from vascular compression. Most often the superior vena cava is obstructed, but obstruction of pulmonary veins with a clinical picture similar to mitral stenosis has been described.²

McIntyre and Sykes credit William Hunter, 1757, with the first authentic description of a case of superior vena caval obstruction, this being due to an aortic aneurysm.¹⁰ They state that in a series of 250 cases of superior vena caval obstruction, 75 to 80% were due to primary thoracic tumor, aortic aneurysm or chronic mediastinitis. Approximately 25% of the cases were due to fibrous mediastinitis. The signs and symptoms of superior vena caval obstruction may be rather dramatic and distressing. There are dilated veins over the upper half of the body with the direction of the blood flow in these determined by the site of obstruction. There is a marked increase in venous pressure of the upper half of the body with resultant edema of the face, neck and upper extremities. This edema is aggravated characteristically in the recumbent position and abates somewhat with assumption of the erect position. Cyanosis may occur in a similar distribution. Glottic edema may contribute to respiratory obstruction. Cerebral symptoms from venous stasis may be a prominent feature.

Carlson experimentally demonstrated various

routes of collateral circulation in superior vena caval obstruction.³ They are: (1) internal mammary route, (2) azygos route, (3) vertebral route and (4) thoraco-epigastric route. The latter develops primarily where the occlusion obliterates the azygos system as well.

If the obstruction of the superior vena cava is above the azygos vein and the azygos vein is patent, the return of flow of blood to the heart is by this route. If the azygos vein is obstructed in addition or the superior vena caval obstruction is below the azygos, the route is by the superficial and deep abdominal vessels and vertebral plexus which return the blood eventually via the inferior vena cava.

The more common superior vena caval site of obstruction is adequately explained from the placement of the mediastinal lymph nodes as described by Rouviere.¹⁷ The trachea and right bronchus are both close to the superior vena cava. Two to five lymph nodes of the right anterior mediastinal chain lie anterior to the superior vena cava. The right laterotracheal chain consisting of three to six nodes lies posteriorly alongside the superior vena cava. The largest and most inferior node in this chain sits on the arch of the azygos vein. These two chains collectively drain the right lung, the lower trachea and proximal bronchi, thoracic esophagus, lower left lung, diaphragm, pleura, heart, pericardium and thymus. Thus any infectious or malignant disease involving these structures may come to involve the nodes closely approximating the superior vena cava. If one accepts this reasoning for granulomatous or malignant obstruction of the superior vena cava, one could project this theory to that of idiopathic sclerosing mediastinitis, assuming that the involved lymph nodes are replaced by dense fibrous inflammatory tissue.

Limited Therapy

Therapy of this condition with fully-developed superior vena caval obstruction has been limited. Attempts at liberating the vena cava from the dense surrounding scar have met with little success.^{4,7,8,9} Bypass procedures have been attempted both experimentally and clinically but immediate success is usually followed by later thrombosis of the interpolated graft.^{6,9,15,19} Various methods of superior vena caval replacement have been studied experimentally.^{13,14,15,16} There is recent experimental evi-

dence that teflon grafts may be the material of choice.¹⁴ Unfortunately, the venous structures are frequently so extensively involved as to make impossible a bypass grafting procedure. Recently, in cases caused by tumor, thrombectomy has been employed with success.²⁰ We are in agreement that the tumor mass should be resected when first seen in the asymptomatic stage and before superior vena caval obstruction occurs.¹ Results following early resection are gratifying.

Esophageal obstruction due to mediastinal granuloma has also been reported, but appears to occur more rarely. Moore has recently reviewed six reported cases and added one of his own.¹² The findings are dysphagia due to an extraluminal midesophageal mass. This usually is associated with granulomata of the subcarinal lymph nodes. In contrast to superior vena caval obstruction, surgical extirpation with relief of symptoms is the usual outcome.

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Evaluation of an Antitussive Drug

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IN 1953, POHLAND and Sullivan¹ reported the synthesis of a series of analgesic drugs. One of these (a, dl-4-dimethylamino-1, 2-diphenyl-3-methyl-2-propionyloxybutane hydrochloride), when studied in animals was found by Robbins⁵ to be equal to codeine on a weight for weight basis. On oral administration to humans, 50 mg of the racemic mixture of d and l isomers were approximately equivalent in analgesic activity to 32.5 mg of codeine.²

Subsequently, the dextro and levorotatory stereoisomers were prepared separately by Pohland.³ The dextro isomer was studied in animals by Robbins,³ and clinically by Gruber and Chernish.³ In man, this isomer (dextro propoxyphene hydrochloride) was found to be equal to codeine in analgesic effectiveness. However, dextro propoxyphene, although analgesic, possessed little if any antitussive activity in animals.⁶ Contrariwise, levo propoxyphene had no measurable analgesic activity but was equal to codeine in antitussive effectiveness.

Experimental studies by Bickerman¹ indicated that 32.5 mg of levo propoxyphene were less effective than 15 mg of codeine and 65 mg of

levo propoxyphene were less effective than 30 mg of codeine. However, Pohland and Sullivan prepared the N-oxide of levo propoxyphene. This drug, when given to animals,⁶ was more than twice as potent as codeine. On this basis clinical studies were undertaken. The N-oxide of levo propoxyphene was found to be nontoxic when oral doses of 200 mg were given four times daily.

Dextromethorphan hydrobromide was also studied by Bickerman¹ in humans. Ten milligrams of this drug appeared to coincide with 15 mg of codeine in antitussive activity and no significant increases in activity were observed with 20 mg. Since this antitussive is also a non-narcotic, it was selected for comparison with the N-oxide of levo propoxyphene.

Method

A co-operative study was established among several research groups. A sample of the report form used is presented in Figure 1. The medications (Figure 2) included in this study were as follows:

N-oxide of 1-propoxyphene hydrochloride, 25 mg.

N-oxide of 1-propoxyphene hydrochloride, 50 mg.

N-oxide of 1-propoxyphene hydrochloride, 100 mg.

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‡ 1245 Eastern Parkway, Brooklyn, N. Y.

225 West Ashley Street, Jacksonville, Fla.

515 Minor, Seattle, Wash.

Report Form Used in the Study

Questions I, II, III, IV, and V were asked before the medication was given. They were then repeated during or after therapy.

Name: _____ Age: _____

Sex: _____ Race: _____ Rx: _____

Diagnosis: _____ Phone Number: _____

Before Medication:

- I. How much does your cough bother you? _____
(1) a little (2) some (3) a lot (4) terribly
- II. How often do you cough? _____
(1) occasionally (2) sometimes (3) frequently
(4) all of the time
- III. How hard are your coughing spells? _____
(1) hacking (2) single coughs (3) multiple
coughs (4) causing loss of breath
- IV. How often do you bring up something when
you cough? _____
(0) never (1) rarely (2) half the time
(3) usually (4) all of the time
- V. What is the most that you bring up? _____
(1) a little (2) some (3) a lot

After Medication:

Did you take your cough medicine? Yes ___ No ___

- I. How much did your cough bother you while
you were taking your medicine? _____
(0) none (1) a little (2) some (3) a lot
(4) terribly
- II. How often did you cough while taking your
medication? _____
(0) none (1) occasionally (2) sometimes
(3) frequently (4) all of the time
- III. How hard did you cough while taking your
medication? _____
(0) none (1) hacking (2) single coughs
(3) multiple coughs (4) loss of breath
- IV. How often did you bring up something when
you coughed? _____
(0) never (1) rarely (2) half the time
(3) usually (4) all of the time
- V. What is the most that you have brought up? _____
(1) a little (2) some (3) a lot
What other effects have you had from the
medication?

	Effect	Score
(1) a little (2) some (3) a lot	_____	_____
(4) terrible	_____	_____

FIGURE 1

Dextromethorphan hydrobromide, 15 mg.

Dextromethorphan hydrobromide, 30 mg.

Blank (cornstarch)

These medications were provided on a double-blind basis as identically appearing capsules. They were packaged in bottles of 28. Thus, one bottle was sufficient for seven days of therapy, four doses per day.

Patients with acute or chronic respiratory tract diseases were used. Most of the patients were

adults requesting therapy for acute upper respiratory tract infections. Since it was probable that no more than seven days of therapy would be necessary, a report with only one medication could be obtained from each patient. Comparison among groups of patients was necessary in order to compare the various medications. All other antitussives were omitted during the study. Other medications (e.g. antipyretic analgesics, antibiotics) were given as necessary for proper patient care.

The cough was evaluated at the initiation of therapy and again three to five days later. This second report was obtained either on a revisit or by telephone. Questions selected are presented in Figure 1. Empirical scales were used to quantitate the severity of different aspects of the symptom. Scores (Figure 1) were arbitrarily assigned in order to determine the variation in cough status. The changes in scores were subjected to analysis of variance.

The patients were also asked to quantitate any other symptoms which occurred during the treatment. Almost all of the reports stated that no other effects were observed. These data could not be evaluated further.

Results

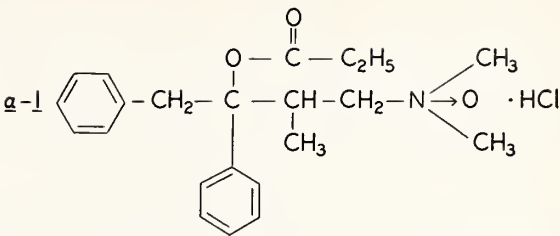
The mean changes in scores are reported in Table 1. The larger doses of both antitussives were associated with significant differences (p less than 0.001) from the effect of the blanks when the question asked was "How hard have you coughed?" The other questions were associated with differences which appeared randomly and never were associated with p values less than 0.025. (When many inter-comparisons are made, it is proper to establish a low p value.) The apparent plateau between 50 and 100 mg of Compound 32997 with all questions remains unexplained.

Analysis of the change in the estimates of intensity of cough associated with the administration of dextromethorphan hydrobromide (15 mg and 30 mg) and levo propoxyphene N-oxide hydrochloride (25 mg and 50 mg) is presented in Table 2. This analysis indicates that the drugs produced approximately the same effects, the greater the dose the more effective the drugs became, and the effectiveness of the doses increased at about the same rate (slope) with the two medications. Therefore, it appears that 1.7 mg of levo propoxyphene N-oxide hydrochloride

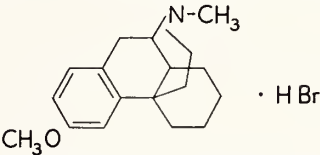
ide is approximately equivalent to 1 mg of dextromethorphan hydrobromide in suppressing cough intensity.

Discussion

Three different questions related to cough were included in the study. Similar reports were obtained with each of these questions. However, significant differences were demonstrated when patients were asked "How hard have you coughed?" and not when the questions were "How often have you coughed?" or "How much has your cough bothered you?" A possible explanation for these results is as follows: The patients may be more conscious of changes in intensity that in the frequency or possibly in the discomfort provoked. Adaption to coughs of low intensity frequently occurs. However, as the cough intensity increases, discomfort becomes apparent. The only statistically significant change reported by these patients was in intensity of cough. Regardless of the explanation of these results, a desired clinical effect was achieved; namely, the patients observed cough



N-oxide of levopropoxyphene hydrochloride



Dextromethorphan hydrobromide
FIGURE 2

of lowered intensity without decreased expectoration.

Conclusions

One milligram of dextromethorphan hydrobromide and 1.7 mg of the N-oxide of levopropoxyphene hydrochloride produce approxi-

TABLE I
Mean Change in the Estimates of Cough

Intensity was determined from subjective estimates made by groups of patients using arbitrarily assigned scores (see Figure 1). The reports after medication were subtracted from those obtained before medication in order to demonstrate change in cough pattern.

		Levo Propoxyphene N-oxide Hydrochloride			Dextro- methorphan Hydrobromide	
	Blanks	25mg	50mg	100mg	15mg	30mg
Number of Patients	27	36	27	28	30	28
Questions:						
I. Bothered by cough	0.703	0.972	1.444	1.071	1.066	1.071
II. Cough frequency	0.740	1.027	1.481	0.571	1.266	1.392
III. Cough severity	0.148	0.527	1.518*	1.428*	0.700	1.392*
IV. Expectoration frequency	0.778	0.527	1.148	1.000	0.700	0.928
V. Amount expectorated	0.555	0.276	0.814	0.678	0.566	0.428

* Significant (p less than 0.001) difference from Blanks.

TABLE II
Variance Analysis

Analysis of the change in the estimates of intensity of cough when 15 mg or 30 mg of dextromethorphan or 25 mg or 50 mg of levopropoxyphene N-oxide were administered.

Source of Variation	Sum of Squares	df	Mean of Squares	F	P Less Than
Medication	0.20	1	0.20		
Doses	21.59	1	21.59	13.84	0.001
Slope (Interaction)	0.66	1	0.66		
Remainder	182.55	117	1.56		
Total	324.00	120			

mately the same suppression of estimates of cough intensity.

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New Pathology Forum

The Pathology Information Committee of the Indiana Association of Pathologists will conduct a "question and answer" column in the Pathfinder section of The Journal. Queries in the fields of anatomic or clinical pathology may be addressed to The Journal, 1019 Hume Mansur Bldg., Indianapolis 4. Answers and discussions will be published periodically.

Meckel's Diverticulum: Clinical and Roentgenologic Signs

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THE DIAGNOSIS of Meckel's diverticulum is seldom established preoperatively. This is not because of its infrequent occurrence. Various autopsy series report a 1% to 4% incidence.^{1,2} It is, however, uncommon as a symptom-producing disease and, when it does produce symptoms, they are usually so obscure and varied that diagnosis is difficult if not impossible.

When positive, x-ray studies are invaluable; unfortunately, they are seldom positive in the acute case. In the "chronic" case, however, they may establish the diagnosis. Generally the x-ray diagnosis is made during the course of a barium enema or upper gastrointestinal x-ray examination for unexplained gastrointestinal bleeding, and is an incidental (and surprise) finding by the radiologist. It is probable that the diagnosis of Meckel's diverticulum would be made more often if it were kept in mind and specifically sought for by the clinician and the radiologist.

It is the purpose of this paper to review the experience with Meckel's diverticulum at the Indiana University Medical Center during the past 20 years and to discuss and illustrate the x-ray diagnosis.

Since 1940, there have been 40 recorded cases of Meckel's diverticulum at the University hospitals. Sixteen of these were "incidental" findings at the time of laparotomy for other disease. Twenty-four were the direct or indirect cause of symptoms. These are listed in Table I. There were 28 males and 12 females; the youngest was a newborn, the oldest 69. Symptomatically, they may be grouped as follows:

1. Anemia, gastrointestinal bleeding and chronic abdominal pain -----7
2. Intussusception -----5
3. Meckel's diverticulitis—with or without perforation -----8
4. Volvulus -----1
5. Accompanying umbilical hernia† ----3

In the 24 symptom-producing cases, nine were in adults and tended to be that group which presented as diverticulitis — with abdominal pain and/or obstructive signs. On the other hand, the cases which presented as intussusception with bleeding were in young children. All of the cases with bleeding showed gastric or pancreatic mucosa in the tip of the diverticulum.

Our findings correlate with those of Jewett and Butsch,³ who reviewed 61 cases at Buffalo Children's Hospital and found abdominal pain, anemia and intestinal obstruction the most common symptoms. They warned that obscure pain and gastrointestinal bleeding in an infant should always suggest Meckel's diverticulum. Hodgson and Kennedy⁴ found that Meckel's diverticulum is the second most common cause of bleeding in patients under age two and the fourth most common cause in the two to six age group. Sloan et al.² found only 19 proved symptomatic diverticula in 20 years at Johns Hopkins Hospital. One-half of these became symptomatic before age 10. During the same period there were

† "Symptom producing" in that the production of an umbilical hernia (congenital), and Meckel's diverticulum are intimately associated embryologically. The vitello-mesenteric duct is the embryologic communication between the midgut and the yolk sac. When it persists in its distal end, an umbilical cyst or hernia results. When it persists in the proximal end, a Meckel's diverticulum is produced.

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PATIENT	AGE	SEX	SYMPTOMS OR CLINICAL FINDINGS	SURGICAL OR PATHOLOGICAL FINDINGS
1	48	M	Incarcerated umbilical hernia	
2	3	M	Anemia, blood and tarry stools	Ulceration with aberrant pancreas in diverticulum
3	1	F	Umbilical hernia	Meckel's diverticulum on posterior wall of hernia sac
4	21	F	Bleeding, anemia, and pain	Gastric mucosa (with ulcer) in diverticulum
5	6 mos.	M	Anemia, bleeding	Gastric mucosa (with ulcer) in diverticulum
6	1	M	Intussusception	Meckel's diverticulum in intussusception
7	21	M	Pain, cramps, and abdominal distention	Inflammatory mass secondary to perforation of Meckel's diverticulitis
8	30	M	Abdominal cramps, tarry stools	Meckel's diverticulum with gastric mucosa
9	2 days	M	Umbilical hernia	Incidental Meckel's diverticulum
10	11	F	Bleeding, anemia, abdominal pain	Meckel's diverticulum with gastric mucosa and ulceration
11	51	F	Abdominal pain, vomiting	Meckel's diverticulitis
12	6 mos.	M	Intussusception	Meckel's diverticulum with intussusception
13	2	M	Pain, vomiting, distention	Meckel's diverticulitis with perforation
14	14	M	Pain, vomiting, obstructive signs	Meckel's diverticulitis
15	6 mos.	M	Intussusception	Meckel's diverticulum in intussusception and perforation
16	41	M	Obstructive signs, pain, fever	Perforated Meckel's diverticulum
17	15	M	Anemia, bleeding, abdominal pain	Gastric mucosa in Meckel's diverticulum with ulceration
18	3	M	Intussusception with obstruction	Meckel's diverticulum in intussusception
19	6 mos.	M	Anemia, bleeding	Gastric mucosa with ulceration in Meckel's diverticulum
20	1	M	Abdominal pain, mass	Volvulus with gangrene of Meckel's diverticulum
21	51	M	RLQ pain, nausea, and vomiting	Meckel's diverticulitis
22	23	F	Pain, nausea, and vomiting with partial obstruction	Meckel's diverticulum with chronic inflammatory changes
23	11	M	Abdominal pain, tenderness, and fever	Perforated Meckel's diverticulum
24	8	M	Pain, obstruction, and bloody stools	Intussusception with Meckel's diverticulum

TABLE I

29 incidental diverticula found during abdominal surgery for other disease.

Many rarer complications of Meckel's diverticulum may occur and are found in the literature, usually as isolated case reports. These include: neoplasia within a diverticulum (carcinoma,¹⁵ leiomyosarcoma,⁴ and neurilemmoma⁶) and foreign bodies within the diverticulum.¹⁷

The diagnosis of Meckel's diverticulum by x-ray examination is rare. It was first recorded by Dr. J. T. Case,⁵ but was first discussed by Pfahler.⁶ Bischoff and Stampfli⁷ found 33 cases

in the literature and added two of their own. The diagnosis was accomplished by barium meal in 20 cases, by barium enema in seven, by injection of a communicating umbilical fistula in one, by visualization of an air-filled diverticulum in one, and by recognition of a calculus in another.

Four Methods of Diagnosis

There are four methods of demonstrating a Meckel's diverticulum by x-ray. The first of these is by the barium meal and subsequent study of the small bowel as the meal passes through it.



FIGURE 1

SMALL-BOWEL study two hours after barium meal. Note diverticulum in left lower quadrant.



FIGURE 2

SAME CASE as Figure 1, at seven hours. Small amount of barium retained in diverticulum.

(Figure 1). Usually diverticula are small and broad-based and apt to be nearly the same diameter as the loops of bowel. These factors tend to prevent it from filling with barium except momentarily. It is imperative, therefore, that the radiologist fluoroscope and make appropriate spot films during a diligent and careful search of the ileum. Such efforts may be rewarded with accurate diagnosis. In one case, a delayed film was of great value in visualizing the diverticulum (Figure 2). The delay allows time for the meal to progress through the small bowel, but sufficient barium is retained in the diverticulum to visualize it. To my knowledge, this has not been previously reported.

A second method is visualization of the diverticulum from below, by overfilling the ileum after barium enema (Figure 3). This method has the advantage of somewhat better-controlled visualization of the small bowel by filling it completely in continuity. This increases the possibility of visualizing the diverticulum if one is present. The diverticulum may occur anywhere in the small bowel, from 2.0 cm to 100.0 cm above the ileocecal valve. Most are found 80.0 to 85.0 cm proximal to the valve.⁸

A third method of x-ray diagnosis of a Meckel's diverticulum is recognizing the presence of a calculus in it. Opaque calculi develop within



FIGURE 3

OVERFILLING of terminal ileum by reflux at barium enema. An excellent way to visualize a diverticulum, for the small-bowel loops can be filled in continuity.

the diverticulum⁹⁻¹⁰ and differ from the usual coprolith in that they are apt to present a characteristic "folded ribbon" appearance⁷ usually in association with a gas bubble. The presence of



FIGURE 4

CALCULUS within a Meckel's diverticulum. The finding of a calculus within a "gas bubble" on the abdominal scout film is a pathognomonic sign of Meckel's diverticulum.

a calculus within a gas bubble on a plain film of the abdomen is pathognomonic (Figure 4).

A Meckel's diverticulum may contain air. Lerner, Levin and Katerman¹¹ described the finding of air in the diverticulum as a "new" sign of Meckel's. Other types of diverticula may contain air, and other conditions may present bubble-like shadows which must be differentiated. For example, lipoma of small bowel, pneumatosis intestinales and intra-abdominal abscesses are conditions which might produce diverticulum-like air shadows on plain films.

There are other indirect signs of Meckel's diverticulum. As mentioned above, these would occur in the complicated case and present the x-ray picture of intussusception, volvulus, or obstruction, depending on the type of complication involved. With one exception, the diverticula demonstrated by x-ray contrast studies are the asymptomatic ones. The exception is the patient with unexplained melena. Since 90% of such patients are found to have peptic ulcer, the possibility of Meckel's is seldom entertained. In a younger patient, however, the diagnostic work-up should include an abdominal scout film and a small-bowel study, with a careful examination for Meckel's diverticulum.

Summary

The experience with Meckel's diverticulum at Indiana University Medical Center during the past 20 years is reviewed. X-ray diagnostic signs are re-emphasized, and reasons for the infrequent roentgenographic diagnosis of the condition are discussed. Useful x-ray signs are visualization of the diverticulum with barium, with air, or with a calculus in it. The value of a delayed film after small-bowel study is mentioned as an aid to more frequent visualization of the diverticulum.

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*The Editorial Board of the Journal is pleased to announce that the following
INTERNS and RESIDENTS have been named winners of the Journal Medical
Essay Contest for 1961:*

First Prize: JOSEPH D. HOWARD, M.D.

Intern, Ball Memorial Hospital, Muncie

Title: *Fear of Death*

Second Prize: MICHAEL H. LASHMET, M.D.

Ophthalmology Resident

Indiana University Medical Center

Title: *Groenblad-Strandberg Syndrome—Case
Report and Review*

Third Prize: GEORGE F. RAPP, M.D.

Orthopedic Surgery Resident

V.A. Hospital, Indianapolis

Title: *Fat Embolism*

These papers are scheduled to appear in subsequent issues of the Journal

The Case of the Devil's Mercy

ARNOLD LIEBERMAN, M.D.
New York, N. Y.



THE SCENE WAS SAD, solemn and somber; the 300-year-old Puritan church was filled with hushed mourners. A young minister was devotedly consoling the bereaved; still, few were really listening to him; in front of the pews was the single adult coffin flanked by *eight* much smaller ones.

Just two days previously, a young mother of five had taken her whole brood (plus three children from adjacent households) to a church social. At its conclusion, she had filled her new station wagon with her little flock and started sedately for home. Suddenly, a careening vehicle, roaring at 90 miles per hour on the wrong side of the street, smashed into them. The crunching crash exploded into flames even as the pursuing police car pulled up. The fires were quenched quickly but it was many gruesome hours before the tangled wreckage yielded the remnants of enough bodies to assemble into their respective coffins. The young assassin's body lay unclaimed; his victims were now only statistics in the annual death toll.

The suddenly devastated families, still benumbed by the total disaster, were gathered among sorrowing friends to bury together those who never knew what struck them. As a doctor in the little community, I had the dismal duty of being present: I had to sedate, to treat and to attempt the prevention of hysterical disintegration. I sat only half listening to the droning ritual.

And then—as it happens so frequently—my ears focused clearly on the minister's words: "*When we pray for new blessings, may we come to Thee in the spirit of humility and submission remembering that we cannot know whether what we ask is really for our good. Thou alone knowest and orderest all things well, whether Thou grantest our petitions or deniest them.*"

Many gears shifted in my mind: a dozen years ago, I was 2,500 miles away. The sun was just rising over the desert as I ambled leisurely astride my cow pony. I was wearing my old officer's uniform; the boots still had the regulation spurs but the grey shirt was unbuttoned

at the collar and the tie was missing. True, the marks of the insignia remained indelible; also true was the fact that the campaign hat was tilted at a most disapproved angle. The War was *over* most definitely for demobilized me. I had risen literally before dawn on the pretext of doing a little target practicing up at the empty arroyo. Actually, I wanted to absorb the glorious beauty of the rising sun bathing the cacti blooming briefly after the transient spring rains.

Multihued, delicate flowers carpeted fantastically the usually bleak, sandy rubble. The velvety lawn effect was enhanced by long, grey shadows cast by the about to rise sun. The air was still fresh, cold and clear. Only a few hundred yards from habitations all was quiet, peaceful and relaxed. It was good to be home, alive and well.

I almost stumbled over a man standing by his horse; apparently, the saddle girth had slipped and he had dismounted to readjust it. Morning mists, while dissipating rapidly, had still concealed us from each other. As he straightened up, I got the overwhelming first impression of colossal size, just sheer bulk. Granted that he wore those loose, fringed buckskins; granted that a huge beard and an outsized sombrero on top of a leonine mane of red hair did not exactly minimize dimensions further aided by out-sized, high-heeled, Western boots: admitting all that, still he was close to seven feet, 250 pounds of masculine bone and sinew! The beautiful stallion by his side was at least twice as large as my horse. It stamped its feet and neighed challengingly. The rifle slung over the stranger's shoulder could have been a spear and his steed, a Crusader destrier on the sands of the Holy Land . . .

From this rearing Kodiak bear, a voice boomed, "Howdy, neighbor! Mighty few fellows out this early! You *are* the new doctor up the street, aren't you?"

Hans Hell is the Name . . .

The words were pure American but the accent was almost vaudeville Norwegian. He noted my surprised start; he went on, "Yah, Hans Hell is the name; no *e* on the end! I come from Minnesota but my pappy came from Hell, Norway. That means light in their lingo and I never saw any good reason for changing the name; rather different, yah?"

He vaulted into his saddle and, turning the

charger toward me, asked, "What are you doing?"

"Well, I had planned to go up this arroyo a ways and do some target practicing with my revolver."

"Mind if I join you?"

"Not at all!"

That was my unconventional introduction to Hans Hell. It was not long before our households got to know each other well. He, also, was a newcomer to the little community. He had a little business selling appliances but that, surely, did not provide him with the wherewithal for his luxurious style of living. He had bought a magnificent ranch house, furnished it sumptuously and staffed it lavishly. He had a stable of splendid horses; no less than five Great Danes roamed around the menage; those enormous dogs still looked large even when their huge master towered beside them.

Hans' wife, Martha, was his opposite in almost every conceivable way. She was small, demure and very quiet, giving the bystander the impression of being submerged by her colossal mate. They had one boy who was—well, shall we say, less than prepossessing no matter which way one looked at him. Bob was a gangling, dull-witted, preposterously pimpled example of everything derogatory that could be said of an adolescent. Mary, their ten-year-old daughter, was the exemplar of everything nice, clean, beautiful, intelligent and wholesome. Both parents doted on her; she was the real link binding the Hells together.

* * *

Sitting at that funeral, I shifted my legs as another flash-back to the Hell family toured my memory. It was the winter of the same year in which I had first met Hans. One late afternoon, very casually, he had invited me to, "Come up to Chet Wood's with me and watch some card games. Wanna wear your holsters with the guns in them—loaded?"

A doctor is not much of a gunslinger even if he is an American Legionnaire. Furthermore, I had always taken a humorously tolerant view of Western exuberance with lethal weapons. Complying jestingly, I turned up in full regalia, both Smith & Wessons tucked into the holsters of my belt. We went into the famous gaming establishment quite openly, as in that state everything went. Passing through the lower floor,

where the smaller games were busying the tourist trade, we wended our way upstairs. Here the stakes were much higher; everything was more selective and serious. I had been in these rooms on several professional occasions to attend individuals stricken with vascular accidents.

Hans cleaved purposefully through the throngs; he seemed to know his way thoroughly. A couple tough characters stood aside respectfully as we strode through a door that I had never noticed previously. We were in a large, luxuriously paneled room. In its center was a table around which sat some half dozen men playing poker. Apparently, Hans had been expected as there was a vacant chair waiting. Cold, interrogating eyes focused on me; seldom have I felt more silly than standing there in that fancy costume of mine.

Came to Treat Attacks

"He is my doctor," boomed Hans pointing at me; "I asked him to come and treat any one having another one of those heart attacks. Eh, Chet?"

The famed operator of the place nodded my way; another face smiled and thanked me for a prescription I had given him some time before. He was known to me as a West Coast gambler with severe asthma; although still in his twenties, Uncle Sam and various assorted D.A.'s were already compiling a dossier on him. The perfunctory introductions were really not needed; I realized that I was in the company of the reigning survivors of the gambling (and worse) Underworld.*

Gus the Greek, Sheeny Sam, Dons of the Mafia, that out-of-place Irishman not long for this world—and Hans. Why did he want me to know how his dollars came to him? I had heard rumors of these fabulous green table jousts; I leaned against the wall in back of Hans' chair and just relaxed, watching quietly.

Almost an hour of decorously monotonous playing slipped by. The room was semi-hushed as the intent gamblers called their decisions; even the bartender circulating with the ordered refreshments refrained from his usual banter; the chips represented wealth unseen by most men in a lifetime of honest employment. And then, Hans was dealt a cold full house; it was dealer's choice and he was the first hand to the

left of the dealer, the then ruler of Capone's captains. Hans looked quietly at the two jacks and three queens he held; his huge paw lay relaxed over the pasteboards; he was waiting to be asked his pleasure. Nervelessly, he tossed in a couple chips saying, "Just to keep you all honest."

To his left was the other Mafia Don—a close associate of the dealer. The dark-skinned player, hardly glancing at his cards, remarked, "I like mine; I bump!" Everybody stayed and it was up to Hans to respond. He seemed to be in no hurry; he looked earnestly at the dealer and then almost turned as he eyed the other Mafioso up and down.

"Do you want to stay?" It was the dealer interrupting the prolonged pause. Again that prolonged deliberation so out of character to the impetuous Viking I knew. And then, Hans tossed the needed chips into the center and spoke in a drawl, "Well, Frank! I tell you! I got a GOOD hand but . . .

GIVE ME THE FOUR OFF THE TOP!
AND:—

KEEP YOUR HANDS ON THE TABLE!!!"

Snap of the Dictate Imperative

The command was still in an undertone but it had the deadly rapid snap of the dictate imperative! With the adjuration, I could all but *hear* the whir of the rattles and the cocking of the 45's. As I jolted bolt upright, I saw the minor hoodlum guarding the door begin to reach for weapons. He was only a step to my left; automatically, I dropped my hand to the gun and pressed the still holstered revolver actually into his side as I whispered, "Take it easy—*pal!*" The sudden change of pace had caught everyone by surprise: no one had moved but I had visions of gun duels as per movie script; I had not had time to be frightened: that was to come later.

Hans seemed oblivious of having said anything unusual; motionless, he awaited the next move. The dealer's poise had been shaken but he recovered quickly; having glanced around calculatingly, he spoke impassively, "Hans! You *sure* you want these four?"

"Off the top!"

"O.K.!" Rather theatrically, holding the deck at an exaggerated height, Frank put down the cards counting to four as he did.

* "The Case of the Comatose Truck Driver" *J. Ind. State Med. Assoc.* 53:3, p. 460.

Without looking at the four he discarded, Hans swept the ones just dealt him under his enormous hand. He did not as much as deign to look at them as he tossed several blues towards the center remarking gently, "Now THESE babies are plenty valuable, don't you all think?"

Only then did he turn towards the Mafioso at his left; the insolent insouciance of his silent uplifted eyebrows deprived me of what little wit I had remaining. The animal trainer was daring the coiled cobra to strike! The challenged lord of the omerta looked around the table; slowly, his somber, smoldering dilated pupils swung around under the heavy, slightly tinted lids. Completing the wide arc, the gangster suddenly shrugged his shoulders and tossed his cards in, "I guess you know what you are doing."

The taut tension uncoiled as suddenly as it had boiled up as, one by one, each successive player refused to stay. Grinning broadly, Hans swept the pot his way. Then, just as casually, he holstered the 45 which had been cradled in his other hand; to this day, I do not know how it had gotten there.

"You know, men! It is time for me to be ambling along." Having said this and smiling most amiably, Hans Hell arose and stuffed uncounted the huge wad shoved his way by the dealer. There was the devilry of pure bravado as he leaned forward and roguishly turned up the four cards he had been dealt; they were the four bullets, all right! "Pretty! Aren't they?"

Fast Escape to 'Caddie'

I was shaking as we backed out of that room and got out to Hans' big Caddie—fast. As he tooted the car back to town, the big slob almost laughed outright as he watched me wipe the perspiration in which I was bathed. "Why, Doc! There never was any danger; those blankety bastards all knew I had them by their balls! But I *am* sorry that their crooked bluff scared you so! Here; have a drink of this." I took it straight.

* * *

Still sitting at the funeral, again I shifted irritably my cramped legs. My mind was reproducing another flashback relating to Hans Hell. It was the summer following the gamblers' duel. The searing sun was scorching the little race track located just outside that little Western town. It was off season—there were no tourists;

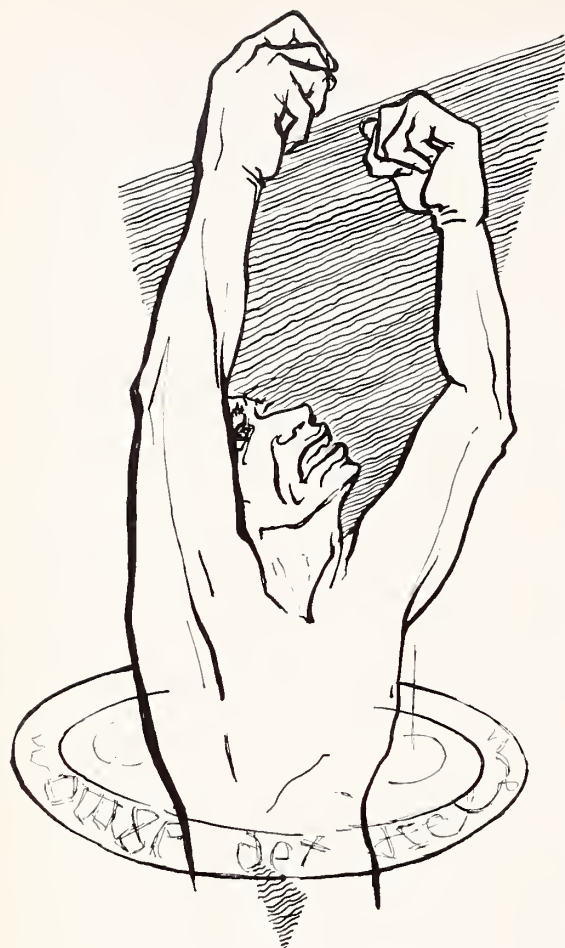
it was almost noon—all sensible people were indoors away from the blinding heat. Hans Hell had bought his darling daughter, Mary, a real riding mare as a present for her eleventh birthday; he had dragged me along to watch the performance his expert little equestrienne was capable of; we had cantered out briefly and had paused at the track to take a turn or two. Besides the three of us on our horses, there was only the pack of Hans' Great Danes trotting along. I was sweaty and tired but relaxed; the background was somnolent, peaceful and just ordinary. And then—as in a nightmare—it became the *mise en scène* of a never-to-be forgotten cascading cataract of action.

One of the dogs had nosed out a little rabbit that dashed suddenly under the very noses of our horses. All five hounds bayed in unison and took off after the little bunny. The sudden explosion of sound made the mounts rear. Even as I check-reined mine, I could see the little girl's mare clench the bit in its teeth, flatten its ears back and bolt down the track. Mary was totally unprepared for the panic reflex of her horse. She was jolted clear out of her saddle; she tumbled forward, the top of her head striking squarely on the hard, sun seared sand. Her neck twisted at a sickening angle as the body followed the head; she flipped over and stretched out supine—sprawled with her hands and feet flung apart full length. The perky little sombrero was still held by the chin strap but her curls were in disarray; and she was so still!

No Suggestion of Life

Even as this was happening, Hans and I were scrambling from our horses. In my frantic haste, my feet never touched a stirrup as I leaped to her side; Hans was already there. There was no quiver of a movement in the utterly limp body; there was not a twitch of a breath being attempted; my fingers could detect no pulse; my ear, pressed to the chest just below her little bud of a burgeoning breast, could detect no suggestion of a heart beat!

Smartly, I thumped my clenched fist over the lower sternum; frantically, I started the two handed, closed cardiac massage. This maneuver has lately been re-popularized by writers from Johns Hopkins but, of course, it has been well-known these many years. Hans was at her head, stooped over and concentrating on the mouth to mouth breathing he was synchronizing with my



grim efforts. I persevered doggedly even though the lack of response seemed terrible confirmation of the horrible neck twisting I had witnessed so plainly. Before my mind was the paralyzing picture of the odontoid process of the second cervical vertebra sinking its fang into the soft, defenseless vital centers at the very base of the brain where it joins the spinal cord.

There was not a word uttered as the ominous minutes ticked away; the horses stood silently, their heads drooping; the culprit mare had dashed around the track and rejoined the other two; the Great Danes—unwitting instigators of the disaster—had returned and sat on their haunches, widemouthedly panting in the horrible heat. I was drenched in perspiration and getting a mite woozy what with the loss of water and salt; I was verging on heat exhaustion if not sun stroke but I simply dared not desist long enough to go for the thermotabs and the canister of water I kept always in the saddle holsters.

Hans was lavishing his all on the inert form

of his darling daughter. The rollicking roisterer, the pistol packing pirate, the fearless freebooter, the brash baiter of the malevolent Mafiosas—Hans Hell was weeping even as his lips were forming silently the words of the Lord's Prayer! Like any terrified child, he was imploring for divine assistance in his extremity.

His face was close to mine but it was beginning to blur; I was conscious of an accelerating pulse and fading vision as my body began entering the definitive stages of heat exhaustion collapse. And then—all at once—there was Hans standing on his feet, shaking his fists at the skies and screaming pagan imprecations! He wanted his babe to live and he was bartering his very soul in trade: To Heaven or Hell?? He did not care which! Somehow, in my physical state, in that place and at that moment, Hans did not seem fatuous, blathering or even demented. It was the cry wrenched from the very depths of an anguished parent.

The harrowing startle of Hans' blasphemies tore me out of the daze into which I had been slipping. Even more electrifying was the sudden quiver of a gasping breath taken by the hitherto inert patient. I thumped briskly just above the xiphoid process; there was another convulsive spasm of the respiratory muscles. I leaned my ear against the body: faintly but certainly there was the regular lub-dub of a normal cardiac rhythm. Mary was reviving!

Coming Back . . . from Where?

Never, in all my life, have I had a greater emotional jolt! Getting up on unsteady feet, I stumbled to my horse; fumblingly, I put a salt tablet into my mouth, washing it down with a long swig of water from the canteen. Silently, I offered both items to Hans; only then did I wipe the blinding sweat from my face and look at my wrist watch. Mary had been without a heart beat and without a breath of her own for at least ten minutes—more likely, fifteen. Yet, by the minute, nay—by the second, she was coming back; from where? Like a punch drunk fighter, she was beginning to sit up, propping herself on the palms of her outstretched hands and shaking her head. In five more minutes, she was *standing* on her feet quite steadily; her speech was coherently clear; she was inquiring as to what had transpired.

I spoke up, picking my words carefully, "That was quite a fall you had, Mary! You

gave us quite a turn. I really think you should go to the hospital for observation; just in case. Don't you think so, Hans?"

Hans Hell looked at me blankly; his mind seemed to be still soaring in outer space. In a bleak monotone, he vetoed the suggestion, "Why Doc! We KNOW she'll be all right; just look at her; it was only a bit of a prat fall. Come along, Mary! Your mother has lunch waiting for us."

The Hells rode their way and I went mine. The Faustus theme was frayed with misuse and not at all credible to me. I was a mid-20th century scientific degrees laden physician: completely materialistic, rational and not a little cynical. I had worked many fruitless quarter hours on hopeless efforts at resuscitation. I had seen the human vegetables existing on the lowest reflex level that had resulted from only five minutes of cerebral anoxia. Mary Hell had been totally pulseless and breathless for probably fifteen minutes: certainly no less than ten.

Of course, I had not had any of my instruments with me. I may have been dizzy from heat exhaustion; things may have blurred to me—BUT! I knew with utter certitude that no human being could have gotten up and walked away from the kind of a fall suffered by Mary Hell. That terrific invocation by the raving father! What followed; and immediately . . . I sneaked into the patio of my house by the back entrance, went into my bedroom unobserved and fell sprawled on my bed; I fell asleep instantly.

The next thing I knew, my wife was shaking me awake while hovering over me anxiously. I had been in the throes of one of those phantasmagoric nightmares in which baying hounds were pursuing my madly galloping pony. Just as I seemed to be trapped in a cul-de-sac of a ravine, an irrational gate swung open and the steed leaped over what looked like the outdoor barbecue in my patio. A gigantic Hans, attired in chef regalia, spitted me deftly out of the



saddle and started grilling me on the glowing charcoal flames. His boisterous laughter was ringing in my ears even as I focused on my loving spouse saying, "This mid-day sun will addle your brains yet."

Sighing with relief, my agreement was meekly heartfelt. I showered, got into respectable attire and went to the office that I maintained in the front of the building. By suppertime, my composure had been regained in toto; the race track events were simply dismissed from my mind; they were too outré for rational analysis and I loathe witzelsucht.

Mary Doesn't Seem Well

Just two days later, who should walk into my office but Martha Hell and her daughter, Mary. The older woman almost apologized for bothering me with trifles. "Since that ride a couple days ago, Mary has not *seemed* too well; Hans would tell me nothing and he is out of town today; Mary *looks* a bit feverish and says her neck hurts her; I do wish you'd give her a going over."

There was no graceful way of evading the issue. Suppressing a grimace of queasy anticipation, I started about the routine of a physical examination accompanied by the standard laboratory tests. To this day, I do not know why or how my probing got diverted into the channels it did take.

Yes, there was a trifle of a sore throat—and did that soft palate sag somewhat unnaturally away back there? There was almost a degree of fever—and was her speech slurred just a wee bit? The muscles did seem to twitch hyperactively—but what made me go into such meticulous neurological details? I *had* brought out undeniable back stiffness when the familiar "kiss the knees" maneuver was used; a little nuchal tightness *was* elicited although I could not say that Brudzinski's sign was REALLY positive—just what decided me to go about the performance of a spinal tap? It was done easily and the fluid *was* under increased pressure and *did* show a rise in the cell count and proteins. The heart tones were excellent and the lungs were absolutely clear—but was there an EXTRA inspiratory effort? True, the superficial reflexes were all present—but were her leg muscles always that weak?

Mind you! Knowledge of virus diseases has grown immeasurably since World War II. If

one picks up a 1944 edition of Osler's text and compares that volume with any contemporary book (say, Cecil's 1960 edition), the great expansion of knowledge becomes obvious. The differential diagnosis facing me that memorable afternoon really included not only anterior poliomyelitis but such syndromes as encephalitis, choriomeningitis, infectious neuronitis (i.e., Guillain-Barré Syndrome), just plain influenza, rheumatic fever, assorted meningitides including the tuberculous variety and not forgetting the "ordinary" allergic and the auto-immune: just a monstrous host of entities.

What hypnotic subtleties made me so absolutely sure of my diagnosis? What mesmeric reasons made me so flatly certain of the clinical course to be taken by the disease? The evidence, so early in the illness, was truly most flimsy; my absolute assurance beyond all effrontery was diagnostic legerdemain that was to earn me a reputation for supernatural acumen — well, maybe, it was. After all, I never mentioned to anyone that dreadful half hour on the race track; that was the basis for what I did. Who and what guided me?

The mundane examination of a patient who did not LOOK very ill in the first place ended by my calling the hospital. I asked for a private room and for nurses around the clock; I ordered the respirator to be ready on a stand-by basis; I placed calls to the pediatrician, the neurologist and the orthopod: I escorted the little patient to an ambulance and rode with her and the almost hysterical mother; I told Martha that I was turning Mary over to the specialists; as Mary was being tucked into her bed, I gave her bluntly my diagnosis—of course, Hans was called long distance.

Paralytic Polio it Was

Before that same midnight, Mary Hell was in a respirator! Both shoulder girdles went out completely. The talented consultants toyed awhile with other diagnoses but PARALYTIC POLIO it was—unequivocally and in its most aggravated form! For the next EIGHT years that lovely child was to lie in that horrible aluminum tube: the ghastly, life sustaining casket whose ends whirled monotonously: endlessly pumping air, first, *in*, then, *out*! Above the neck was the Madonna-like, infinitely patient face framed by her lustrous, combed curls and illuminated by the bright, keenly-intelligent

eyes. Below the neck: there was only the wasted skeleton ravished of all muscular structures; the skin kept clean of bed-sores only by dint of the fabulous efforts of the coordinated medical team that devotedly kept Mary alive.

Not many years ago, Mary Hell's face decorated the annual Jan. 30 poliomyelitis campaign stamp. While I resided in that town, I made it a ritual to see her every time I went to our little hospital. . . .

* * *

These flash backs out West require much time for transcription; my mind had wandered away from that old Puritan church for not too many actual seconds. I was back, mind and body—back at that funeral. The minister had fumbled his trend of thought and had paused for lack of anything else to say. He gathered himself together and repeated clearly and firmly.

"We cannot know whether what we ask is really for our good. Thou alone knowest and orderest all things well, whether Thou grantest our petitions or deniest them."

There was greater comprehension in my gaze at the coffins. The sonorous swing of the Biblical injunction somehow made tremendous good sense to me: I felt that I was on the verge of grasping their true meaning. If Mary Hell had lain in just such a little coffin after the race track accident?? What would those at *that* funeral have thought and felt??

Of course, I am no theologian. However, as a plain doctor of medicine, it occurs to me that a simple recital of my reflections might serve a purpose. There just might be some comfort in it for others: for those beside me and even elsewhere. . . .

1270 Fifth Avenue
New York, N. Y.

LABORATORY MEDICINE

Published periodically as a review
of clinical laboratory procedures
suitable for laboratories with minimal
equipment.

Ketone Bodies

A. WENDELL MUSSER, M.D.*

KETONE BODIES are intermediate products of fatty acid metabolism. In certain disease states, these "ketone bodies" accumulate in the blood and are excreted in the urine. Some of these compounds are not actually ketones, but have been traditionally given this name. They consist of acetoacetic acid and B-hydroxybutyric acid and acetone. These products are known to be derived from acetoacetyl CoA in the metabolism of fatty acids.

Through complex enzyme systems, acetoacetic acid is formed, which in turn can be transformed into B-hydroxybutyric acid. Acetoacetic acid can also be decarboxylated to acetone. The ratio of acetoacetic acid to B-hydroxybutyric acid in the serum depends a great deal upon the presence or absence of liver glycogen. An ample supply of liver glycogen favors the formation of B-hydroxybutyric acid and a low liver glycogen favors the formation of acetoacetic acid.

Caused by Several Factors

Ketosis which consists of ketonemia (increased levels of ketone bodies in the serum), ketonuria (increased levels of ketone bodies in the urine), and an acetone odor of the breath, may be caused by several factors. The diabetic patient has a decreased level of catabolism of carbohydrates. Intermediates of carbohydrate metabolism usually shunted into the citric acid cycle are now used in the formation of acetoacetic acid

and other ketone bodies. Starvation produces ketosis by a chain of events beginning with the loss of liver glycogen, continuing with retardation of the citric acid cycle and ending in the accumulation of acetoacetic acid and other ketone bodies. Renal glycosuria stemming from many causes may result in ketosis by means of a mechanism similar to that of starvation.

Ketosis, from the aspect of the natural poisonous properties of the compounds themselves, is not important. The concomitant acidosis is of grave importance, associated with the forces acting against the necessary physiologic electroneutrality of the body, that is, the general loss of sodium with the urinary excretion of the ketone bodies. Large quantities of water are lost via the urine daily. This combined with the usual poor oral intake of fluids subtends severe dehydration.

The need for a reliable test for ketone bodies (acetone and acetoacetic acid) is evident. Recently a commercial company has manufactured a stick test, and in the past, a tablet test for ketonuria. Since these ketone bodies are readily excreted in the urine and since urine is usually readily available, this method has become quite useful and popular. Although this method is simple and reliable, reliable standard chemical methods should always be available for checking and even standardization in time of emergency. The tablet methods involve the interaction of ketone bodies with sodium nitroprusside in the presence of glycine. Sodium phosphate is added

* Formerly at Indiana University Medical Center; now at Womack Army Hospital, Fort Bragg, N. C.

as a buffer, and lactose as an intensifier of the color produced.

METHODS

Acetone in Urine (Lange's Method)

To about 1 ml of urine, add 1 to 2 drops of acetone reagent. Tilt the tube and layer the urine mixture with concentrated ammonium hydroxide. Allow the mixture to stand approximately two minutes. After this time, examine the mixture for a reddish-purple ring at the juncture of the two fluids. If the ring is present, report the results as faint trace, trace, 1+, 2+, 3+, or 4+ acetone. If the test for acetone is positive, test the urine for acetoacetic acid by the Gerhard's method given below.

REAGENTS

1. Acetone reagent: Freshly prepared. Mix together equal quantities of a 10% (w/v) solution of sodium nitroprusside and glacial acetic acid. Do not use if the solution has a bluish color.

2. Ammonium hydroxide, concentrated. Fresh.

Acetoacetic Acid Test (Gerhardt's Method)

To about 3 ml of urine, add 10% (w/v) ferric chloride solution, drop by drop until no more precipitate of phosphate forms. The development of a burgundy red color upon the addition of more ferric chloride indicates that acetoacetic acid may be present. If a burgundy red color develops, place a portion of the test in another

test tube and heat in boiling water bath to near boiling. Compare the heated portion with the unheated. If the color fades on heating, the urine is positive for acetoacetic acid. Report as positive or negative.

Reagents:

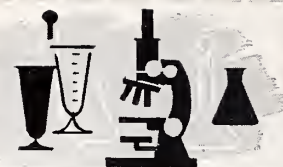
1. Ferric chloride, 10% (w/v).

Certain drawbacks are present with each method. In the acetone method, large amounts of amorphous urates will produce a brown or orange ring. High concentrations of creatinine (3% or over) will produce a brown ring.

In the acetoacetic acid method, the burgundy color may be masked if the patient is receiving any of the coal tar products such as aspirin, acetophenetidin, salicylates or saccharin. The color, however, will disappear upon boiling the mixture. Thiazine derivatives (Sparine, Thorazine, and Phenergan) will produce false positive reactions.

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Know the Difference

AS A PHYSICIAN, you probably have young people asking you about potential careers in the medical ancillary fields—many of them will be interested in medical technology.

They may ask you specifically about a school you have never heard of. Before you offer any advice about a school, you should be sure you KNOW THE DIFFERENCE in schools.

There are some "schools, colleges, and universities," which supposedly offer to young people just out of high school complete training in the field of medical technology, even though they have no college background. These schools are usually operated by lay persons and in some instances are "fronted" by physicians who apparently do this as a sideline. Be advised that the only acceptable qualified training for registration which will be recognized over the entire Country requires a minimum of three years of college preparation, followed by a minimum of

one year in a laboratory where a definite training curriculum is established, supervised by a pathologist and qualified medical technologists.

In case this differentiation is too involved, one can easily establish the type of school by simply asking if the training is approved by the Council on Medical Education of the American Medical Association, the American Society of Clinical Pathologists, the American Hospital Association, the Canadian Hospital Association, and the Catholic Hospital Association. If the answer to these questions is no, then one cannot conscientiously advise any young person to spend the fairly large sums which these schools charge for tuition (some as much as \$1,000 to \$1,200 for one year), when he or she will end up with substandard training which is not recognized by any of the above bodies.

Know the difference and know the approved schools in your own State which are listed together with the pathologist in charge as follows:

Anderson:

St. John's Hickey Memorial Hospital
D. L. Buckles, M.D.

Evansville:

Protestant Deaconess Hospital
F. E. Mills, M.D.
St. Mary's Hospital
F. W. Porro, M.D.

Fort Wayne:

Lutheran Hospital
W.D. Griest, M.D.
Parkview Memorial Hospital
K. R. Schlademan, M.D.
St. Joseph's Hospital
L. A. Schneider, M.D.

Gary:

Methodist Hospital of Gary
W. P. Loh, M.D.
St. Mary's Mercy Hospital
E. J. Shalgos, M.D.

Hammond:

St. Margaret's Hospital
J. Pilot, M.D.

Indianapolis:

Indiana University Medical Center
J. L. Arbogast, M.D.
Methodist Hospital
L. H. Hoyt, M.D.
St. Vincent's Hospital
L. Foster, M.D.

Kokomo:

St. Joseph's Memorial Hospital
M. W. Rudicel, M.D.

Lafayette:

St. Elizabeth Hospital
G. B. Stansell, M.D.

Michigan City:

Michigan City School of Medical Technology
R. J. Frost, M.D.

Muncie:

Ball Memorial Hospital
L. G. Montgomery, M.D.

Richmond:

Reid Memorial Hospital
J. D. Stepleton, M.D.

South Bend:

South Bend Medical Foundation
J. R. Bennett, M.D.

Terre Haute:

St. Anthony Hospital
J. C. Lee, M.D.
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L. L. Blum, M.D.

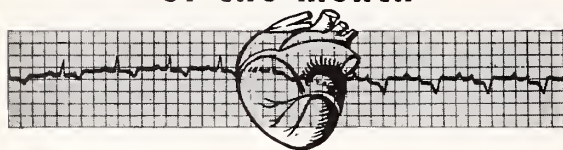
Vincennes:

Good Samaritan Hospital
B. K. Black, M.D.

In the December Journal

Complete coverage of
the 1961 ISMA Annual
Convention, including
business proceedings of
the House of Delegates
and a picture story of
convention events.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Giant Negative T Wave

CHARLES FISCH, M.D.*
Indianapolis

INVERSION OF T WAVES is a rather common, but unfortunately, a nonspecific finding. On rare occasions, and usually because of other accompanying changes, one is able to assign a specific etiology for the observed T wave alteration. For example T wave inversion coupled with a prominent U wave most often suggests hyperkalemia, or an inverted T with a short Q-T interval is more specific for digitalis than any other cause of T wave change. The significance of T wave change varies so that, on one hand, it may indicate a serious myocardial disturbance such as coronary disease but on the other hand identical change may be observed with hyperventilation as a syndrome of no consequence. On rare occasions, however, one encounters "giant" symmetrically inverted T waves which are seen almost exclusively in patients

with myocardial infarction, and interestingly enough, in patients with cerebro-vascular accidents.

Case Report

The patient whose cardiograms we wish to present was an 83-year-old woman who was admitted to the Marion County General Hospital on July 7, 1961, with symptoms and findings of congestive heart failure and cardiac enlargement confirmed by roentgenography. The electrocardiogram taken on July 11, 1961, (Figure 1) showed atrial fibrillation. The QRS complexes in leads II and III exhibited deep S waves indicative of intraventricular conduction delay. T waves were low in I and inverted in AVL, V-4, V-5, and V-6. Although the inverted T waves are symmetrical and thus suggest myocardial ischemia, in view of the fact of digitalis medication, they must be considered as nonspecific. There was gradual improvement in the patients condition until July 20, 1961, when she developed a severe substernal pain and a clinical diagnosis of myocardial infarction was made.

*From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association, Indiana State Board of Health and the National Heart Institute (H.T.S. 5363).

An electrocardiogram obtained on the next day, when compared with tracing recorded on July 11, 1961, showed an overall increase of the voltage of the QRS with strikingly large negative T waves accompanied by prolongation of the Q-T interval. The increase in size of the QRS complex is difficult to evaluate, but it was not

due to an error in standardization. Perhaps the same factors, namely ischemia and consequent electrolyte alteration which are inevitable when the cell membrane alters its permeability and which are responsible for the T wave abnormality may also be responsible for increased amplitude of QRS. ◀

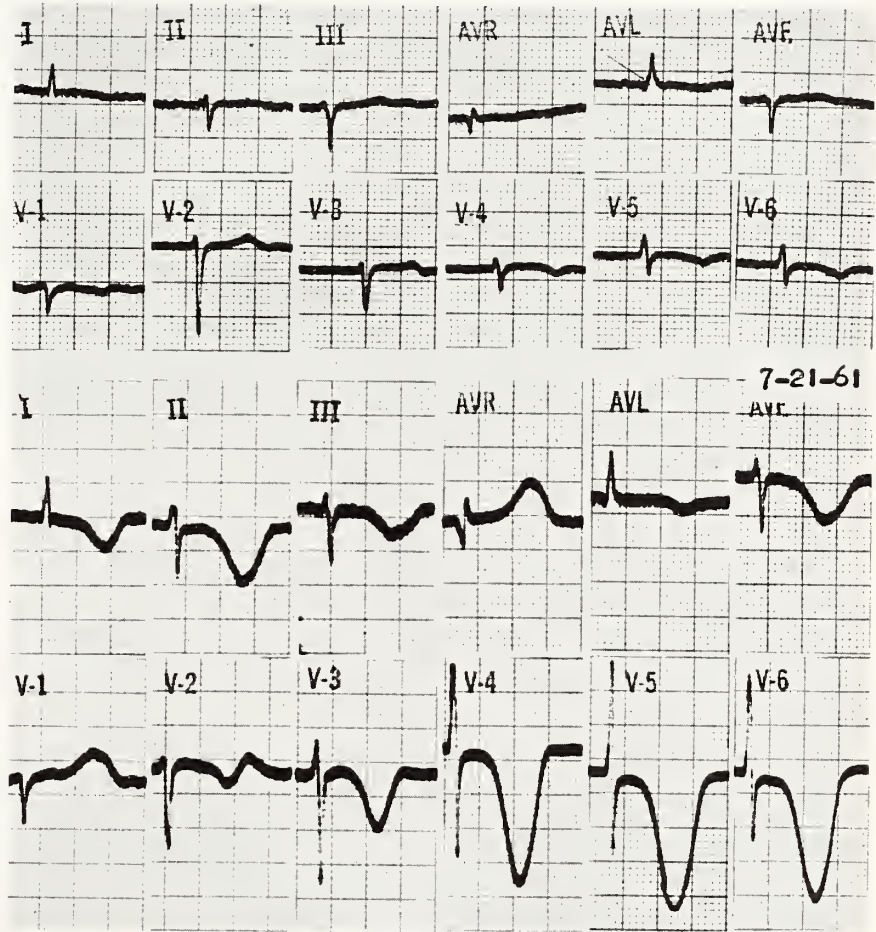


FIGURE 1
TRACING TAKEN on July 11, 1961, shows atrial fibrillation and nonspecific T wave changes. Cardiogram recorded on July 21, 1961, shows increased voltage of the QRS and huge inverted T waves.

blood pressure approaches normal
more readily, more safely.... simply
with
Salutensin[®]
(hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

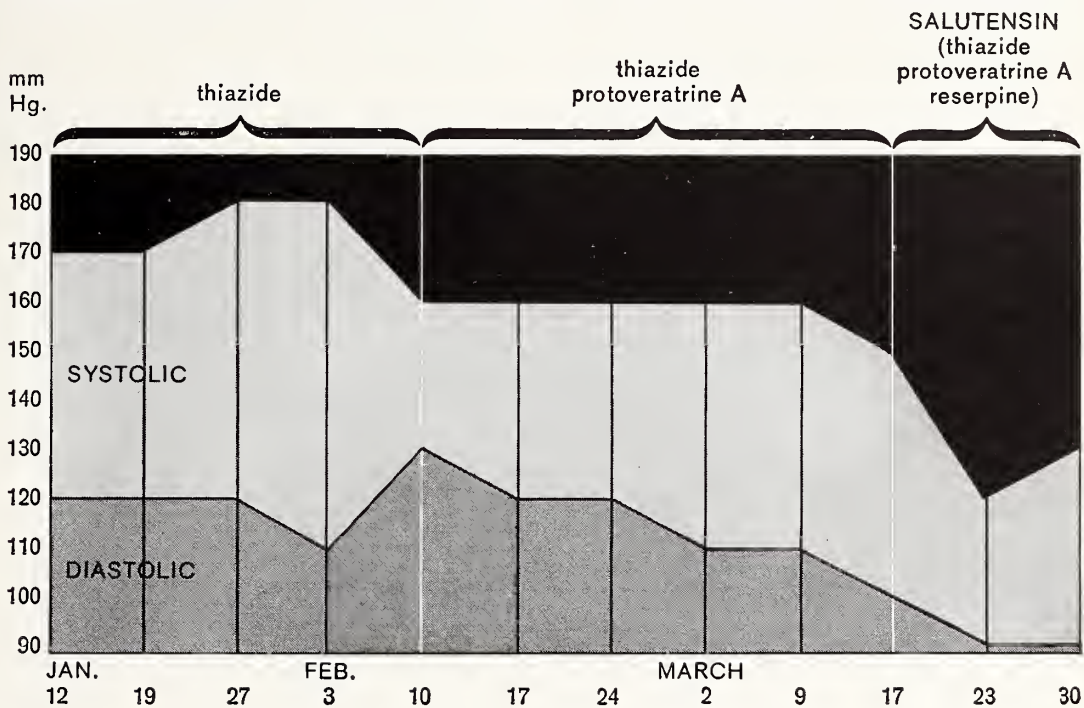
Supplied: Bottles of 60 scored tablets.

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all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

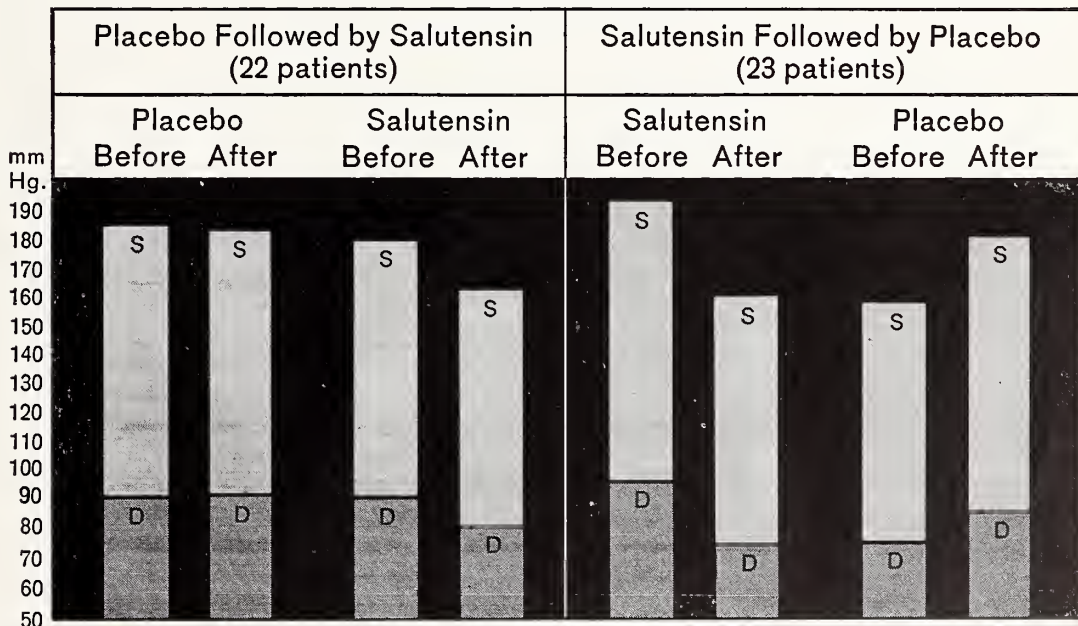
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.



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Doctor Diplomats

SIX PHYSICIANS from Indianapolis are giving up their practices to serve voluntarily for three-month periods in the Congo as part of the Congo Protestant Relief. **Dr. Richard M. Nay** arrived in Northern Rhodesia early in October. He will be followed in succession by **Drs. Hunter Soper, B. T. Maxam, Herbert Sedam, James M. Jay and Robert Pickett.**

This service is one of many currently in operation, supported by church and public contributions and encouraged by the AMA. The Indianapolis doctors are participating under the guidance of the Indiana Conference of the Methodist Church under Bishop Richard C. Raines.

Five physicians from Tulsa, Oklahoma, members of the First Presbyterian Church of Tulsa, are serving for six-week periods at the Miraj Medical Center in Miraj, India.

Other groups of American physicians are also becoming interested in the possibility of initiating a similar venture in their own communities. For example, several doctors met during the

AMA meeting in June to discuss the feasibility of adopting an overseas program which would provide medical care to other areas of the world equally in need of assistance.

Still another example of American physicians demonstrating their interest and willingness to serve in foreign mission fields on a temporary basis is shown by the large number of doctors who have written to the AMA Department of International Health in the last few months to inquire about such service. This new Department administers a program approved last June by the AMA House of Delegates whereby members of the AMA may volunteer for service in the foreign mission fields on a temporary basis when emergencies arise. Cooperating with the AMA in this program are missionary agencies representing every denomination sponsoring American medical missionaries.

Physicians interested in volunteering for such services are asked to write directly to the AMA Department of International Health, 535 N. Dearborn St., Chicago 10.

Triamcinolone Acetonide

ANY NEW DRUG added to the armamentarium of the present day physician may soon be expected to find alterations of its applications and modes of introduction into the human.

Such an example is presented in the article published in this month's issue¹ concerning the use of a glucosteroid drug intralesionally. In this particular report a drug has been found to be very effective intralesionally which was at first thought to be useful only by systemic administration. Often only small amounts of the insoluble glucosteroid are needed to produce good clinical results.

To date, localized areas of hyperthrophic lichen planus, circumscribed neurodermatitis, resistant psoriasis, keloids, discoid lupus erythematosus, acne cysts in conjunction with antibiotics, synovial cysts of the dorsum of the fingers, necrobiosis, small patches of alopecia areata (not necessarily permanent regrowth) and

pruritus ani are among the dermatological conditions which have often favorably responded to this mode of therapy. Remissions had been reported to have lasted as long as 10 months.

No systemic sequelae have been recorded. The drug is injected infrequently and only in small amounts. Thus, the complications of systemic administration are readily bypassed.

Limitations of this therapeutic procedure most commonly encountered are the discomfort and pain when it is injected and some atrophy of the skin noted if the suspension is not placed correctly in the subepidermal area.

Undoubtedly new techniques will be developed to hasten its delivery, and to place the material at the correct level each time it is administered.

Another interesting and effective therapeutic procedure for dermatological lesions seems to have been achieved. More will be heard of it.

S. R. Mercer, M.D.,
Fort Wayne

¹ Booth, B. H.: Administration of Triamcinolone Acetonide in Dermatological Disorders, p. 1635.

Patrolling Is Key to Good Record

MOST TURNPIKES are much safer than ordinary rural roads. The record for the 18 U. S. turnpikes in 1950 was 2.2 deaths per 100,000,000 vehicle miles, whereas all rural roads in the country except the turnpikes were charged with 7.1 deaths for the same mileage.

Indiana is average or very close to it in this respect. In 1960 the Indiana Toll Road had a fatality rate of 2.5, and the remaining rural roads in the state duplicated the national figure of 7.1.

That such good records are not the automatic result of turnpike safety construction features is attested by the fact that for some years and for some turnpikes the rate is higher than that for ordinary rural roads; and at times the turnpike rate may be much higher than it should be.

The Indiana Toll Road, for instance, has had years with rates of 4.6 and 4.5; better than the state average but not good enough. West Virginia Turnpike in 1957, 1958 and 1959 had fatality rates of 14.0, 8.0 and 13.5 before getting it down to 2.9 in 1960.

Turnpikes are as safe as modern engineering and construction can make them. Sharp turns,

steep hills, narrow bridges, intersections, poor visibility, oncoming traffic and stoplights except for toll stations have all been eliminated. The turnpikes unattended, however, cannot eliminate the dangerous, careless and unsafe driver and that is the part of the safety program which pays off the most.

Constant patrolling to eliminate dangerous speeding, drunken driving, sleepy drivers and obviously careless drivers is necessary to prevent the death rate on turnpikes from being higher than that on common roads.

Indiana Toll Road police gave tickets to 725 speeders in one month. In one year 6,000 motorists were convicted of violations on the Indiana Toll Road. This is the method by which a thruway is made safer than an old fashioned country road.

The 41,000 mile National System of Interstate and Defense Highways should be completed by 1975. It is estimated that this system will carry one fourth of all motor vehicle travel. If policed as efficiently as our present turnpikes the fatality rate should be lowered considerably.

Editorial Notes . . .

About 2.5 million people in this country are at work in the health field. When the 1960 census figures are available they may show that health work has risen from seventh to third place in point of persons employed in all major industries. That is a lot of industry. Health Information Foundation reports that the greatest increase in late years has been in workers of all types who perform technical tasks which relieve the physician for work which only he can perform. The increased efficiency of physicians thus obtained helps to offset the increased training time and the time spent in postgraduate training.

Small World Item: Sunday afternoon before Labor Day a Venezuelan physician needed some of Lilly's new drug for treatment of Hodgkin's disease. A 'ham' radio operator in Caracas started a message which was picked up by a Pittsburgh 'ham' on vacation with his portable set in Florida. Thence to an Indianapolis 'ham' who called Lilly's. The Velban reached Caracas 29 hours and 29 minutes after the Caracas radio operator asked for it.

ECG tracings may be made by use of the radio-electrocardiograph without any wires to connect the patient and the recorder. The patient wears a pocket-sized radio-broadcasting transmitter which operates on a special frequency. The device, named the RKG 100, has been used to make tracings of patients during exercise. Many patients who had normal tracings 30 to 60 seconds after cessation of exercise were found to show abnormalities during exercise.

Major medical expense insurance had a later start than hospital, surgical and ordinary medical coverage, but it is now gaining in popularity at an enormous rate. At the end of 1960, 27,448,000 persons were protected; 5½ million of them were added in 1960. More than \$430 million was paid to beneficiaries in 1960, almost \$95 million over the previous year. Most major medical expense policies pay medical expenses such as special nursing costs which cannot be paid by straight hospital insurance. To do this at a premium that people can afford, major medical is written with deductibility and co-insurance features. It avoids paying on a multi-

tude of small illnesses and does its best work on the big catastrophic illnesses that don't happen very often but are extra expensive.

Unfamiliarity with trade jargon has brought about and perpetuated an erroneous statistic during the past several years. "Drug Topics Red Book" is an annually published list of products sold by drugs stores. The 1953 edition was advertised as listing 140,000 medicaments with an increment of 14,000 new drugs in 1953. These figures have been quoted ever since then and rather frequently whenever drug sensitivity or multiplicity of drugs was discussed. The figures are erroneous for such discussions since medicaments when used by "Red Book" refer to any items sold in a drugstore and include lipsticks, perfume and prescription drugs and everything else in the store. Even in the case of drugs each dosage size and each package size is listed as a separate item. Actually the total number of medicinal products is probably not larger than 12,000, and many of these are not marketed nationally. New drug products each year number somewhere near 400.

A Federal Court in California has refused to ban the sale of dietetic chocolate candy sweetened with saccharin and sodium cyclamate. The Food and Drug Administration sought to eliminate the candy, which is made for diabetics and those who seek to lose weight, on the grounds that it was not true candy and contained adulterants. Judge William T. Sweigert ruled that the law in regard to prohibiting "non-nutritive substances" in candy meant only substances which are harmful or fraudulent. He found that substances such as saccharin were neither harmful nor fraudulent.

Soon after the chemotherapeutic treatment of tuberculosis became possible the death rate for the disease fell rapidly but the number of cases under treatment and the number of new cases discovered either remained the same or increased. The latest report by the Indiana State Board of Health however, shows that in the past nine years the rate of newly reported cases has fallen from 46.9 to 34.1. The decrease has been steady and except for two of

those years each one of the nine years has seen a lower rate as compared with the previous year. The rate for active cases has shown the same decline. The death rate in the same period has improved from 12.4 per 100,000 to 5.2. Another statistic of interest is that in 1955 the bed capacity of tuberculosis hospitals was 1596 with 82% occupied, and in 1960 the capacity was only 1309 of which only 79% were occupied.

Patterns of Disease, the Parke, Davis & Company professional publication, presented a thoroughgoing summary of the air pollution problem in the September issue. Most air pollution is man-made. It varies with climatic and geographical conditions, but is at its worst where people are the thickest. Patterns cites a report of respiratory disease in five cities, each with a different concentration of sulfates in the air. Sickness insurance claims per 1,000 employed women in these cities added up to 85.7 claims per 1,000 in the city with the highest concentration. In order of decreasing concentration of sulfates the claims per 1,000 were 58.3, 50.3, 44.2 and 18.5.

Students at Jefferson Medical College Hospital are being oriented in diagnosis and the cost of diagnostic tests by being furnished with a price list of laboratory procedures and being required to maintain a chart of diagnostic costs on some of the ward patients. The result is said to be twofold. First the students acquire a practical knowledge of what an unrestrained total laboratory workup amounts to. Second their instructors have noticed that discussion of the nature of the diseases under consideration and matters of physical diagnosis have been on the up and up recently. This is a program that has long been overdue.

Regular medical expense insurance is on the big increase. In 1950 77 million people were covered by hospital expense insurance. A few more than one out of four of these persons had regular medical expense coverage. In 1960 132 million had hospital coverage, and two out of three of these were covered for regular medical expense. The Health Insurance Institute also points out that benefits paid on medical expense are increasing considerably faster even than the

number of people covered. Last year the people covered went up 8.1%, the benefit payments were up 17.8%.

Natural disasters are characterized by their tendency to destroy medical supplies and at the same time increase the need for such supplies. The Pharmaceutical Manufacturers Association reports that almost 40 of its member firms have an established policy of replacing without charge damaged or destroyed pharmacy stocks not covered by insurance. These firms are large enough to account for almost all the prescription drug production in the U. S. Individual pharmacists, even though short on financial resources at the time, are able to maintain an adequate supply of vital drugs.

The Indiana Attorney General has ruled that it is unlawful for a prescription mail order firm to use a post office box in Indiana for the purpose of receiving prescription orders by mail. The law states that "it shall be unlawful to accept any prescriptions for filling or compounding at any place or establishment not holding a Permit to operate a Pharmacy." The Attorney General said that the receipt of mail orders from a post office box constituted accepting prescriptions, and since the firm in question does not hold an Indiana Pharmacy Permit the Board of Pharmacy has ordered it to cease and desist. The action was taken in regard to Spiegel, Inc. of Chicago. Similar action has been taken by the states of Pennsylvania, Maine and North Carolina.

The reliability of the recent Kellogg-McNerney study of hospital usage may be judged by the fact that one of the findings was announced as "Average size of the hospital bill decreases as the percentage of the patient's participation in payment increases" and that one of the recommendations in the same report was "Fiscal controls of hospital overuse through insurance and prepayment features, such as deductibles, coinsurance provisions and ceilings on indemnity payments, should be viewed with extreme caution; they have a strong association with low volume of care." One of these statements is wrong. Either the committee made some bum findings or their recommendations are irrational.



HARRY R. STIMSON, M.D.
President
Indiana State Medical Association
1961-62

Dr. Harry Stimson of Gary was installed as president of the Indiana State Medical Association during ceremonies following the Annual Dinner at the Columbia Club on October 25.

Dr. Stimson is a native Hoosier. He was born in Marengo and attended school in Gary. He was graduated from Indiana University with an A.B. degree in 1925 and received the M.D. degree in 1933 from Rush Medical College. His intern year was spent at Roseland Community Hospital near Chicago, following which he had a residency at Sedgewick County Hospital in Wichita, Kansas. He practiced a year in Genoa, Nebraska and in 1936 returned to Gary where he has been busily engaged in general practice ever since.

He was married in 1933. He and Mrs. Stimson have a son of college age and a daughter who teaches school in Gary.

Dr. Stimson is well known for his activities in community affairs and his county medical society. He is a Kiwanian and a Trustee of the Presbyterian Church. He served as president of the medical staff of Gary's Methodist Hospital in 1955. He has been secretary of the Lake County Medical Society for two years and was its president in 1955. He was a delegate to the state association for 10 years.

Dr. Stimson is noted for his willingness to accept assignments involving controversial matters in medicine, and well known for his ability to adjudicate differences of opinion and arrive at reasonable conclusions. He has served well on the State Committee on Medical Care Insurance, the Public Relations Committee and the Commission on Government Medical Services. He has been a member of the Medicare Committee and is chairman of it now. He was recognized for his experience in prepaid medical care by being appointed as one of the two representatives for medicine during negotiations to formulate medical insurance plans for the steel industry.

He was also an outstanding chairman of the state Committee on Medical Education and Hospitals when many controversial issues were raised in regard to hospital accreditation. He is at present a member of the Indiana Blue Shield Board of Directors. He is a charter member of the Indiana Academy of General Practice and has served that organization as a delegate.

Dr. Stimson assumes the presidency after an extremely busy year as president-elect.

President's Page

EXTRA-CURRICULAR

This is defined in the standard dictionary as "as or pertaining to those activities which are not a part of the curriculum, but form an important part of college or school life." We can all remember how very important these activities were to all of us in our undergraduate life. They were important to us as individuals but also were very important to us as members of organizations such as fraternities, sororities, etc. Why were they important to us as members of groups? This was because the more of our members that became active in outside and campus activities, the more influence we as individuals and as members of organizations could wield in our small world known as the campus.

Now let's attempt to make an analogy between this above and our present position as individual physicians and as members of a great FREE ENTERPRISE known to us as the private practice of medicine. There is no doubt that all physi-

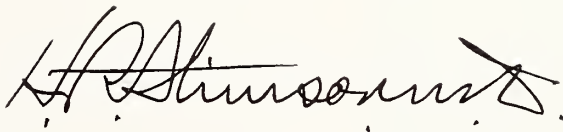


cians are vitally interested in things medical and this is shown by the constant advance in medical knowledge in this country. But there are things which are definitely medical and which can threaten the very life of American Medicine which often appears as "a wolf in sheep's clothing" and is not recognized as being medical by busy physicians unless these physicians have the opportunity to meet them and learn about them in other avenues and organizations which are not directly connected to medicine. There are more groups and organizations, not necessarily medical in scope, making it their business to delve into medical care in all its facets, than any other field that the writer can think of.

Therefore it is urgent that all of us take just as much interest in so-called "extra-curricular" activities now as we did in our college life, and it is much more important of course because it can make the difference between eventual regimentation of American Medicine and the much higher level free enterprise practice of medicine as we now know it. Activity of our members in the various Chambers of Commerce, Junior Chambers of Commerce, United Fund or Community Chest organizations and other similar worthwhile groups is not only desirable but necessary. Then there are the service clubs in which we usually find ourselves pretty well represented. All of these groups at times attempt to take sides in controversies involving our interests and they certainly can be influential in helping to mold public opinion. Even our churches have groups which can go a long way in shaping public opinion on health care and certain of our churches have been very active in this field. After a certain large church meeting held in May of this year in an eastern city in which this

group discussed at length whether or not to go on record as supporting the King Bill or HR 4222, a certain influential clergyman of this denomination told me that numerous people at this convocation remarked at the conspicuous absence of medical men among the lay delegates. When we are practically told where we are lacking it seems to me to be about time to do something about it. Incidentally, this church group turned down the proposition supporting this legislation.

Then there is probably the most important activity of all, that is politics and legislation. Few of us have time to run for office ourselves but the ones who are serving in both the national and state legislature are all doing an outstanding job. But even if we do not run for office we can and must become active with our support, both financially and physically, of candidates who will listen to our story, and I contend that all we will ever need in this fight is someone who will listen to our story without bias, then we can win, for I believe we are right.

A handwritten signature in dark ink, appearing to read "H. P. Stinson". The signature is fluid and cursive, with a large initial "H" and a stylized "P".

The Woman's Auxiliary

REPORTS TO ISMA

ALL ABOARD for Gary, Wabash, French Lick, and Indianapolis! Eighteen state officers and chairmen packed their suitcases with the Auxiliary's program; then unpacked and presented the program in a most attractive and enthusiastic manner in each of the four Areas in the state. What a thrill to have our portable program received with such wholehearted approval, and repacked to be taken home to the counties!

The heady aroma of success was everywhere. Mrs. Otis Bowen, Legislative Chairman, found that OPERATION COFFEE CUP (where the Ronald Reagan record on socialized medicine is played for our friends and neighbors) is going much better than we realized. The AMEF sisters, Mrs. William Symon and Mrs. Donald Meier, told us that over \$3000 worth of Christmas cards had been sold for AMEF by the end of August. (Forty percent—40%—goes to AMEF.) This is remarkable considering that not a single Auxiliary meeting had been held at that time. Mrs. Richard

Potter's records, showing that 80 *Bulletin* subscriptions were sold in July, indicate an upsurge in interest in Auxiliary goals. This magazine is our "textbook" put out by National.



Unwavering attention was accorded to Mr. Converse's talk on Blue Cross-Blue Shield; to Mrs. John B. Kelly's thought-provoking skit on Civil Defense; to Mrs. Charles Alvey's explanation of the HOMEMAKER SERVICE; and to some new ideas from Mrs. William Kleifgen on Medical Careers Recruitment. Talks on Rural Health by Mrs. Robert Seibel, and on Organization by the President-Elect, Mrs. Thomas Johnson, were also well received.

Never before have so many been congratulated on a job well done. The officers and chairmen not only put on a bang-up program at these all-day workshops; they also helped to get their audience. Each wrote a letter—some wrote two—to her corresponding county officer or chairman. This means that many wrote 120 personal letters urging attendance. But it is the county presidents who deserve the final credit for "bringing them into the tent," as the circus saying goes. Some brought their entire boards.

As we traveled, we continued our efforts to get a good attendance. In the evenings we wrote letters to all who could not attend at Gary and Wabash asking them to try to come to French Lick or Indianapolis. To our delight, many did come, although attending outside their own Areas meant traveling greater distances in some cases.

One of our members, Mrs. Robert Fargher of LaPorte, was principal speaker of the day. Her "Politics Went to My Head" received enthusiastic acclaim. The title of her humorous but meaningful presentation is appropriate, since she is the originator of the "Nixon hat" used in the presidential campaign.

The first Vice-President, Mrs. Kenneth Schneider, presided at Indianapolis; the second Vice-President, Mrs. Bernard Hall, at Wabash; the third Vice-President, Mrs. Irvin Sonne, Jr., at French Lick; and the fourth Vice-President, Mrs. Harry Stimson, at Gary. A telegram from Ronald Reagan to Mrs. Schneider asking that she encourage us to continue the good work on OPERATION COFFEE CUP, added an extra fillip to that day's proceedings.

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The Food and Drug Administration and

THE UNITED STATES Food and Drug Administration has been in existence for 55 years. During this period, it has established an unsurpassed record of public service and unswerving devotion to its basic task of protecting the public against the adulteration and misbranding of foods, drugs, cosmetics and devices. It has been singularly fortunate in having a lineage of administrative officials wholly and uncompromisingly dedicated to their tasks.

While this devotion to a mission is fortunately not unique in governmental service, it would be purposeless and uncritical to profess that all governmental employees are equally devoted. With this in mind, I have no hesitation in saying that it would be difficult, if not impossible, to find a more earnest, conscientious and effective group of workers than those who have been and are responsible for the affairs of this organization. It is amazing how successful they have been in resisting subjective pressures. But, at the same time, the agency has subsisted on a starvation diet of Congressional appropriations. This situation has been vastly improved, however, in recent years with the active support of the pharmaceutical industry, and recently, funds have been received for a new and separate building, now under construction, that will house its activities.

During its more than half century, the Food and Drug Administration has been permitted by the various administrators and secretaries of the departments, of which it has been a unit to enjoy a high degree of autonomy. This in itself served to insulate it against political interference. However, former Health, Education and Wel-

fare Secretary Flemming changed this. More than any of his predecessors, he became the spokesman for the Food and Drug Administration, conducted press conferences and public meetings concerning its affairs and identified himself widely with the agency's decisions. This reached a peak of notoriety in the now famous "cranberry" incident. There is a serious question in the minds of many who have a high regard for the Food and Drug Administration and are sympathetic with the objectives for which it has so vigorously striven, whether his action in bringing this agency into the political spotlight has been a beneficial step from a long range point of view.

Voluntary Compliance Traditional

The Food and Drug Administration has always conducted its affairs on the principle that it could function most efficiently by exerting every proper influence to bring about voluntary compliance with the law and its regulations by the industries over which it has jurisdiction. This enforcement philosophy has been expressed repeatedly by its responsible officials. It was pointed out, in effect, that a "cops and robbers" relationship with the vast and responsible industries under its supervision, involving endless litigation, was time-consuming and gave the public less protection for its tax dollars than steps to bring about compliance with the agency's views on a voluntary basis. At the same time, officials were also undoubtedly aware that voluntary compliance avoided unfavorable court decisions which sometimes occurred when least expected. The industries concerned were repeatedly complimented for their fine cooperation with the

The Pharmaceutical Industry

THEODORE G. KLUMPP, M.D.

New York, N. Y.*

Government which not infrequently involved giving the Government the benefit of the doubt—which the courts could not be counted on to do.

Appoint Task Force

In 1960, a three-man task force, under the chairmanship of Charles H. Kendall, appointed by Mr. Flemming to study the operations of the Food and Drug Administration, recommended in effect that this policy be modified and that the Food and Drug Administration deal at arms length, and to all intent and purpose in court, with those subject to its authority. The Kendall Committee report stated, "Because of the limitations and dangers inherent in it, we are of the opinion that industry self-regulation cannot be expected to fulfill the purposes of the food and drug law." It is significant that the Medical Services Task Force of the Second Hoover Commission on Reorganization of the Executive Branch of the Government, which also studied the operations of the Food and Drug Administration, made no such recommendation and indeed complimented the Administration on its pattern of operation. In my opinion, this recommendation of the Kendall Committee is a retrogressive departure from the finest ideals of law enforcement in a democracy. After all, why shouldn't the "regulated" and the "regulator" first talk it over? If they can't agree, the Government can always go to court.


In September and October of 1937 at a time when the deliberations and hearings of the Con-

gress on a new Food, Drug and Cosmetic Law were drawing to a close, the "elixir of sulfanilamide" tragedy occurred. The fluid vehicle, diethylene glycol, in which the drug was suspended, had been inadequately tested and proved to be highly toxic, causing the death of 73 persons. This was directly responsible for the prompt introduction and adoption by the Congress of the New Drug Section of the Act. This provides in effect that a manufacturer may not market a new drug without first submitting satisfactory evidence to the Food and Drug Administration for establishing the safety of the proposed new drug. Without question this one stroke of legislation has had a more profound effect on the critical evaluation of new drugs than anything that has occurred in more than a century. It gave the breath of life to pharmacology, transforming it from a minor subdivision of physiology and clinical medicine to a full fledged scientific discipline coordinate in status with the classical branches of anatomy, physiology and pathology.

The Food and Drug Administration has not had an easy time administering the New Drug Section of the law. It has encountered great difficulty in recruiting sufficient numbers of highly qualified scientists and physicians to do the work. As a group, professionally and scientifically trained persons are not readily attracted to careers in which regulation, law enforcement and litigation play so predominant a role. As a result, the Civil Service lists of eligibles are cluttered with applicants who for one reason or another have failed to advance in the more usual channels of scientific and medical endeavor. The

* President, Winthrop Laboratories, and a member of the board of directors of the Pharmaceutical Manufacturers Association.

Continued on page 1686



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FOOD AND DRUG

Continued from page 1681

difficulty of finding and identifying a few grains of wheat among so much chaff can hardly be appreciated by those who have not had the task. That the Food and Drug Administration has done so well in this respect is another tribute to the persistence and resourcefulness of its principal officers.

No Yardstick for Safety

The proper administration of the New Drug Section of the law is made particularly difficult because there are no absolute yardsticks by which safety may be judged. It may be categorically stated that there is no drug that is not capable of doing harm to some individuals. "One man's meat is another man's poison" also applies to drugs. The task of weighing the possible harmful effects of drugs against the good they do, calls for not merely judgment but wisdom of the highest order. As an interested party, with perhaps the benefit of more than one point of view, it seems to me that the Food and Drug Administration has done a remarkable job in applying the majesty of law to a subject that cannot be removed from the realm of opinion. The fact that in a span of 23 years there has been almost no litigation involving the Food and Drug Administration's decisions in this respect attests to the soundness of its views. It can also be regarded as a credit to the drug industry's collective sense of responsibility and regard for the public welfare.

Recent political developments appear to have exercised a noticeable adverse influence on the processing of New Drug Applications by the Division of New Drugs in the Bureau of Medicine of the F.D.A. With the Senatorial spotlight on the F.D.A. the medical officers seem to be fearful of releasing new drugs. In this politically-charged atmosphere, the fear is that a released drug might turn out to produce adverse reactions which could be seized upon by critics of the F.D.A. as evidence of its incompetence. The officials of the F.D.A. no doubt know that the slightest incident could be magnified out of all proportion to its significance and given widespread publicity to the discredit of the agency. Under these abnormal circumstances, it is understandable that prudent men would be extremely cautious. On the other hand, this attitude can be prejudicial to the public interest if carried to

the point of paralysis or lead to the indefinite postponement of decision through minor and technical objections advanced ad infinitum, but having no real bearing on the safety of the drug.

Congress appreciated the injury that unreasonable delay could cause by providing in the law that New Drug Applications must be acted on within 60 days; but the F.D.A. was also given the right to extend this period an additional 120 days by notifying the applicant before the expiration of the initial 60 days. It was obviously contemplated that the consideration of most applications would be completed within the 60 days and the extended time reserved for exceptional cases. If this were not the obvious Congressional intent, it would have been very simple to have provided a single initial six-month period instead of the two steps enacted into law. But the F.D.A. in its practice often goes well beyond the time limitations prescribed by the Congress. Increasingly over the years, it has refused to file New Drug Applications submitted on the theory that the 60 and 120-day clock does not start running until the application has been accepted for filing. Not infrequently the reasons given for refusing to file a New Drug Application appear to be trivial. They often represent matters that should be weighed as evidence of safety rather than as a basis for refusing to file the application.

New Drug Applications Delayed

It should be clearly understood—and I am certain my views in this respect are shared by the industry generally—I believe strongly that the Food and Drug Administration should have adequate time to consider New Drug Applications. It should not be forced to resort to rationing and artificiality to gain such time. If the staff of the F.D.A. is not sufficient in number and quality to provide more prompt consideration of New Drug Applications, the Congress has the obligation to see to it by increased appropriations, and otherwise, that this important responsibility is adequately discharged. On the other hand, I am convinced that the F.D.A. has added unnecessarily to its own burdens in administering the New Drug Section of the law. It includes many drugs as "new drugs" which by no stretch of the imagination were intended by the Congress to be so regarded. It calls for the submission of data on manufacturing processes

Continued on page 1690

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FOOD AND DRUG

Continued from page 1686

and yields, and other matters, that have little or no bearing on the fundamental question covered by this section of the law. It insists that any change at any time, however minor, in the composition or labeling of a drug, causes it again to become a New Drug. It has found in the New Drug Section of the law a convenient and powerful mechanism whereby many aspects of labeling and even advertising can be controlled without recourse to other specifically pertinent provisions of the law that provide more equitable safeguards against arbitrary, capricious and unreasonable action by administrative officials. In other words, on a weak and tenuous theory, the New Drug Section of the law has become an administrative catch-all and a reasonably complete law within itself. There is something to be said for this policy as an easy and non-litigious way of attaining the agency's objectives. But, at the same time, it has the effect of bogging down the New Drug Section of the F.D.A. where delays are most serious.

In conclusion, I would recommend that officials of the Food and Drug Administration might ponder on the booklet, "The Costly Time Lag Between Discovery and Use of Medical Knowl-

edge," published by its own Department of Health, Education and Welfare. This theme also expresses the single most serious blemish in an organization that over the years has proved itself to be a zealous and effective guardian of the integrity and purity of all the food, drugs, devices and cosmetics that we consume and use. ◀



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Re: H. R. 4222:

Statement of the Indiana State Medical Association Before the House Ways and Means Committee, The House of Representatives

By DON E. WOOD, M.D.
Indianapolis
August 4, 1961

*M*Y NAME is Don E. Wood, M.D., a practicing physician of Indianapolis, Indiana. I am Chairman of the Executive Committee of the Indiana State Medical Association.

The Indiana State Medical Association consists of 82 county constituent societies, representing the 92 counties of Indiana, with 4,317 practicing physicians throughout the state.

The policies of the county societies are established by the physicians who are members of each county society. They, in turn, elect the delegates to the Indiana State Medical Association Convention and through them establish the policies of the State Medical Association. The Indiana State delegates and similar delegates from other states, elect the American Medical Association delegates who in turn attend the American Medical Association National Convention and establish the nationwide policies of that Association. Thus, the policies of the national, state and county organizations are made through a system of representation directly responsible to the practicing physicians. Therefore, the physicians of Indiana, speaking through their Association, appreciate this opportunity accorded them to present testimony to this committee.

The physicians of Indiana have evidenced an interest in the health of the people of the state which, along with the medical research scientists, has resulted in the citizens of our state

enjoying the finest health care of any group of people anywhere. There is a fundamental reason for this pattern of success. It is inherent in the system we enjoy, of absence from coercion by government, which has permitted an unprecedented release of individual talent. Each physician in Indiana has been free to practice medicine as his own sense of individual responsibility dictates. The system has proved the best in history and we believe it is not wise for the central Government to force upon the physicians and citizens of Indiana the socialized systems of Europe, which compare unfavorably with our system.

Solves its Own Problems

Indiana has a reputation for solving its own problems and does not view with approval attempts at outside interference. The citizenry of Indiana, including those in the medical profession, feel it is our God-given right and responsibility to chart our own course, and resolve our own problems in a harmonious manner through individual initiative and local self-government.

Also, Indiana citizens feel that a fair interpretation of the Constitution of the United States would preclude, on a legal basis, encroachment of the Federal Government into this area of state and local responsibility. However, assuming the Federal judiciary might condone usurpation of power by the Federal Government, such

as is now proposed in the field of medical care, it is our judgment that adoption of the proposed legislation would be unsound because:

- 1. Indiana has demonstrated and is demonstrating that it can take care of its own problems.
- 2. The proponents of Federal interference magnify the problems we do have out of all proportion to their importance.
- 3. Federal Government interference would result in wasteful bureaucratic meddling, which would not only dry up a great source of private capital and stifle individual initiative, but would also lower the quality and increase the cost of medical care now available to Indiana citizens.

Indiana has and continues to take care of its own problem.

History shows that the medical profession was the first organization concerned with the subject of health. In Indiana, as has been true in most states, establishment of our State Board of Health was due directly to efforts of the medical profession. The Indiana medical profession was responsible for establishment of the first Food and Drug Act in the nation. The federal government adopted, almost word for word, Indiana law. Today every organization in Indiana working to bring better health practices to the people has had as their first supporter the medical profession.

Submitted herewith is data concerning our state with respect to people over 65 years of age. Parenthetically it should be noted that we do this even though we question whether there is a valid basis for such an arbitrary class distinction.

- 1. According to the 1960 census there are 445,519 citizens of Indiana age 65.
- 2. Of these, 46.3% of the males and 8.5% of the females are employed.
- 3. Of these, 300,560 own their own homes.
- 4. Only 26,874 on the average, or approximately 6%, are on the welfare rolls.
Thus, 94% of the citizens of this state over 65 years of age are caring for themselves out of either income, savings, insurance, pensions or other non-welfare sources.
- 5. Of the 445,519 over age 65:
 - A. 111,510 are drawing pensions and retirement income from private sources.
 - B. 364,191 are drawing income from public sources presumably earned by private

contributions. These Social Security receipts total \$270,656,796 per year.

- C. 367,000 are eligible and covered by:
 - (1.) The commercial insurance carriers -----125,000
 - (2.) Blue Cross-Blue Shield 130,000
 - (3.) Veterans -----112,000

Total -----367,000

- 6. Less than 2% of the citizens over 65 are patients in nursing homes. Of the 8,470 people over 65 who are patients in nursing homes, over 50% (4,870) are paid for from *private* sources. Only 2,132 cases are fully paid for by welfare, plus 614 paid for by township trustees.
- 7. Indiana hospitals are supplying data to us for a given current period on the *admissions* of people over 65 and the *method* of payment. What is available now is set forth in Table I.

Surprisingly, many hospitals do not have a single case of an unpaid hospital bill for the period reported. The information contained in this table is non-selective and fully reflects reports that had been received from throughout the state at the time this statement was prepared. (NOTE: Over 68% of Indiana hospitals have reported so far. This is a much larger percentage than

Continued

Hospitals Reporting Admissions of People 65 Years of Age and Over for a 30 Day Period			71
Total Admissions 65 and Over for Period			4,357
54.26% Paid by Insurance	2,364		
34.91% Paid by Cash	1,521		
8.90% Paid by Welfare	388		
1.93% Unpaid	84		
-----	-----		
100.00%			4,357
Hospital Beds in Indiana			
Total Number Hospital Beds now Available			30,004
Number Beds Being Added by Remodeling Now in Process			1,088
Number New Beds Being Added by Construction of 6 New Hospitals			486
-----			-----
Total Beds Available and in Process			31,578
Nursing Home Beds in Indiana			
Total Nursing Home Beds			9,512
(No Figures Available on Additions By Remodeling or New Construction)			

TABLE I

used in many sample statistical surveys. For example, the Gallup Poll is based on only approximately 1,500 inquiries out of the many millions of people in the 50 states.)

8. Indianapolis General Hospital: Here is a striking example showing that people over age 65 are being given the help they need without charge. For the year 1960, out of 1,808 patients over 65 years of age, 1261 were given free service, while the remaining 547 paid part or all of their bill.

Trained Physicians

Indiana is increasing the number of physicians it is training. Our state school, originally planned to train 40 physicians per year but in 1960 trained 200. A new medical training center has been established under Indiana University in Indianapolis, at a cost of many millions of dollars. This is a recent development. Also, recently an additional two-year medical school, especially designed for students interested in medical teaching and research has been established on the campus at Bloomington. Physicians of Indiana are voluntarily contributing annually over \$50,000 cash and thousands of hours of time without charge, to the improvement of medical education in the state.

During the past ten years the number of physicians in the state has increased by 500. There is now approximately one physician for every thousand population in the state.

Rural Health

Some claim there is urgent need for more physicians in rural areas. Among the numerous active medical society committees in Indiana is our Rural Health Committee and through it we actively cooperate with chambers of commerce, rural and civic groups to avoid any lack of adequate facilities for rural areas.

No legitimate case of anyone's suffering for lack of medical care is permitted to exist if the need is made known to organized medicine.

We could, but realize it is unnecessary, enumerate many instances of physicians providing free care for anyone who needs it, and also making sacrifices to attend to the needs of their patients.

Insurance

Elderly Indiana residents enjoy unrestricted opportunity to obtain health coverage under the Blue Shield and Blue Cross plans. At no time have persons over 65 been denied the right to this service due to age or physical condition. In order to compete, other commercial insurance plans generally avoid any restrictions.

Blue Cross is now offering post-hospital home care, providing for nurse's service, drugs, et cetera, on a basis which provides an incentive to reduce unnecessary hospital care and substitute adequate home care. For each reduction of one day of eligible hospital care, home care is increased four days.

The physicians of Indiana support and endorse all legitimate private competitive health insurance plans. We participate in organizing and directing such plans. We believe they can and will be further improved, if they are not destroyed by government interference.

This is the bright road to improvement of the finest health care in the world in keeping with our free choice system of taking care of ourselves.

Voluntary vs. Compulsory Health Care

Fortunately a striking example of the difference between our highly successful system of health care based on *voluntarism* and a less successful system based on *compulsion* is available here in North America to compare and study.

The following facts are indicative of the waste to be expected when individual responsibility is usurped through government paternalism.

	INDIANA BLUE CROSS PRIVATE VOLUNTARY SYSTEM Indiana (Voluntary)	SASKATCHEWAN, CANADA GOVERNMENT COMPULSORY SYSTEM Saskatchewan (Compulsory)
Population Covered	843,046	827,698
Admissions per 1,000 (All Ages)	115.5	208.8
Average Length of Stay (Days)	7.3	10.1
Annual Days per 1,000 Admissions per 1,000	838.8	2,107.3
(Over 65 Years of Age)	220.4	390.3

The foregoing figures show that:

A *compulsory* system compared to a *voluntary* system creates an artificial demand for more hospital care which ultimately means the local community will be forced, directly or indirectly, to finance additional unneeded beds and facilities.

There has been some criticism of over utilization of hospital facilities under voluntary plans. Obviously these types of complaints which are

Continued

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medicine—

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mental iron, 10 mg.), 30.4 mg. • Iodine (as KI), 0.1 mg. • Calcium (as CaHPO₄), 35 mg. • Phosphorus (as CaHPO₄), 27 mg. • Fluorine (as CaF₂), 0.1 mg. • Copper (as CuO), 1 mg. • Potassium (as K₂SO₄), 5 mg. • Manganese (as MnO₂), 1 mg. • Zinc (as ZnO), 0.5 mg. • Magnesium (MgO), 1 mg. Supply: Bottles of 100 and 1,000.

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minor under a *voluntary* plan would swell to major proportions under a *compulsory* plan.

Knowing how the private competitive free choice system here has shown a capacity and drive which achieves progressively higher levels of efficiency and lower costs, in the absence of inflation generated by government, we anticipate the Indiana Blue Cross comprehensive voluntary plan will continue to improve.

Indiana is deeply concerned about the effect of diverting savings from private channels of banks, insurance companies and other private institutions which are much closer and more responsible to the communities they serve than the huge, ponderous, far-removed federal government.

Taxes

With over one fourth of the income of the people now being absorbed by federal income taxes it is unthinkable to further increase the power of the central government by channeling another one fourth of the income of the people into the control of government through so-called "social security taxes."

The present Assistant Secretary of Health, Education and Welfare, Mr. Wilbur J. Cohen, made it clear on March 23, 1961 before the Senate Committee on Finance that he feels social security taxes should exceed what a citizen is currently paying as federal income taxes.

Such a doubling of federal taxes would greatly reduce the supply of private capital and further increase dependence on an all powerful central government. This is not only socialization of medicine but this is monopolization of finance with a vengeance.

This exposes the naked grab for complete power over the economic life of the nation which is being deliberately manipulated under the disguise of taking care of the medical needs of the aged.

Newspaper reports appearing in Indiana on Monday, July 24, stated that the President had requested Congress to increase social security taxes another ten percent to provide medical care of the aged under social security.

Information Misleading

Here is an example of the misleading information being given to the people of our nation by those who would centralize all facets of

government under one director in order to create government paternalism and dependency.

Any person who gives the time to study similar plans in other countries quickly comes to the conclusion that even the ten percent, while it may sound not too high, is merely the beginning of increased taxation which will eventually, if not unchecked, drain off the very life blood of our nation. Secondly, the public is led to believe that this program will provide complete medical care for all over 65 years of age. This, under the terms of the bill, is not true inasmuch as only those eligible for, or receiving, social security would qualify, and then only for hospital and nursing home care under certain conditions, with medical care limited to provision of professional services in the hospital diagnostic department. In other words, this legislation does not legislate, nor can any legislation be written which will provide for, the complete health care of the peoples of our nation. Many times we forget the fact that health is a state of being which cannot be legislated or made compulsory. Health is dependent upon the individual's following good health practices to develop and maintain his own state of good health.

Aged Financially Sound

You will note in Table I that 71 hospitals within the State of Indiana participated in supplying us with figures concerning the admissions and payment of hospital charges for those over 65 years of age. It is interesting to note that out of 4,357 admissions during a given month, only 84 patients, or 1.93%, had been unable to or had not as yet paid their bills.

Yet the proponents of this measure magnify the problem of less than two percent of our population as though it were a problem of the vast majority of our population over age 65. Logically, then, we can ask the question, "What will this bill do that is not already being done or available to be done, other than to provide another avenue for taxation of the American public, further centralize government, with further government domination of free enterprise, and make our population poorer from increased taxation until they reach the point where they have no recourse other than to become wholly dependent upon government?" Yet these proponents of this measure say it is not socialism—if not, what is it that such a program will lead

Continued

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RE: HR 4222

Continued

us into? In the history of any nation, where the people have become wholly dependent upon central government, we find the development of a dictatorship along either communistic or socialistic lines.

Is it necessary then, we ask, to further increase the tax burden of already over-burdened taxpayers, to provide what is already being provided through local effort and local initiative?

Care Already Available

All people, whether they be 65 and over, or younger, today have access to necessary medical and hospital care, when actually needed, regardless of their ability to pay.

This care is today being provided at the expense of the individual rendering the service or the community in providing the hospital and nursing home facilities. This measure is designed to stop this philosophy of "the good Samaritan" and instead to transfer this responsibility to the federal government at the expense of the workers of this nation who are trying desperately to provide the basic necessities of life for their growing families over and above their continually growing tax burden.

The last session of Congress adopted the Kerr-Mills Bill, which, while not a dire necessity, was nevertheless adopted into law. If we must have a law on this subject, then the Kerr-Mills legislation constitutes a sensible and realistic approach to the problem as seen by the proponents of this type of legislation. The only difference is, and I suspect the main objection to, the Kerr-Mills method is that it retains local jurisdiction rather than Washington dictation, and provides a mechanism for providing financial assistance on a basis of legitimate need, instead of a blank check to all regardless of need.

The planners do not like the welfare program as operating in Indiana, but to us it is a plan which could well be adopted by the federal departments if they have a sincere interest in actually assisting those in need, rather than developing a huge bureaucracy which no doubt covers up a waste of the taxpayers' hard-earned money.

Welfare Burden Alarming

Even today as these hearings are being held, the federal bureaucracy is critical of the people of Newburgh, New York, who have taken a hard, long, honest look at what was happening

to their community under the presently advocated paternalistic approach.

This is, also, the objection the Department of H. E. & W. places upon the Indiana program. In our state, we still believe in states' rights, and by the same token, we believe the local community has the right to develop and operate its own welfare programs, developed on the basis of existing need within the respective communities. Therefore, each of our 92 counties develop and administer locally their own welfare programs, staying within the framework as laid down by Washington mandate.

H.R. 4222 Unnecessary

We believe this new proposal is unnecessary, and, from our discussion with many older people, is unwanted. It is another attempt to regulate, and, therefore, socialize our people and those rendering services to the people. It is another attempt to restrain individual initiative, to pauperize the youth of our nation to the point where they cannot help even their own families, let alone their parents. It is an attempt to legislate a condition of wellbeing which cannot be legislated, to publicize a need which does not exist and to duplicate services already being given without expense to the taxpayers of the nation without the cost of expensive federal administration.

In addition to these points, it is still admitted by the proponents of H.R. 4222 that the Kerr-Mills approach is still necessary.

This is true. The present law provides a method of providing assistance to all regardless of their ability to pass the means test of being eligible for social security. It provides a system of rendering assistance on the basis of need, as judged by the people of the local community in which the need might arise. It provides a system of federal grants in aid to the states, without the development of a larger and more expensive addition to our present federal administrative bureaucracy.

What is our Future?

Therefore, unless it is the avowed intent of some of those in government to bring to an end an era of freedom for the people of a nation, through a system of taxing them beyond their means, then we see no need for this legislation. The job is already being done by the people themselves through their own initiative and through their local communities. Let us en-

Continued on page 1704



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and are of the proper texture. (Testing for vitamin C comes later.) Homer Jackson knows that these oranges are of a quality to meet the exacting regulations required by the Florida Citrus Commission.

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oranges will be nutritionally best for your patients. It will contain abundant amounts of vitamin C and rich, natural fruit sugars.

It's good nutrition to encourage people to drink orange juice. It makes good sense to persuade them to drink orange juice that you *know* tastes good, has the right sugar-acid ratio, and is packed full of nutritionally important vitamin C.

RE: HR 4222

Continued from page 1700

courage this system of solving our problems and not develop any further the philosophy of Washington being the only place where problems can be solved.

It is difficult for us to understand how these burgeoning "cradle to the grave" domestic programs are going to be paid for from tax funds when this nation faces now—right now—one of the most grave international crises in its history—a crisis which, by the best estimates, is going to call for even more financial sacrifice on the part of the already over-burdened populace.

Most thoughtful persons, we are sure, have little or no objection to meeting whatever cost may be necessary to preserve our way of life from foreign ideology. We do believe, however, that they do have serious objection to piling atop taxes necessary for our proper defense still additional amounts for needless domestic programs.

Even if programs such as the current proposed legislation were necessary (as this one is not) it seems foolhardy to try for their implementation at a time when the future is so dark on the international scene and the prospect is great for



"Now does that hurt?"

sacrifices never before demanded of the people of this country.

Back in my home community, one of our local newspapers recently carried a series of articles relating the foolhardiness of many people in buying, on credit, many major items which they did not need and for which the sum total of payments far exceeded their ability to meet from their paychecks. The ultimate outcome, of course, was financial chaos and total bankruptcy.

How could a person be so foolish, we ask? Yet, we now have before us a proposal endorsed by the federal government suggesting that exactly the same thing be done—that is, living beyond taxable means to purchase a program for which there is no need.

What Price Progress

The doctors of this country long have been accused by the social planners—the group behind the legislation now under study—of being against anything progressive.

It is not our intent here to dignify that charge with an answer—we will let the advances in medicine speak for us and the record in that instance is clear for all to see.

We do categorically deny that physicians are opposed to "progress". But if "progress" means endorsement of unneeded schemes and plans the cost of which cannot even be calculated with any degree of accuracy, then the doctors plead guilty to being "against progress".

The facts and figures we have presented provide ample evidence that Indiana can and will meet and solve its own problems—costly, paternalistic legislation from the federal government will not solve anything—it will only compound the problem. ◀

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General Surgery, One Week, March 5
General Surgery, Two Weeks, December 11
Gynecology, Office & Operative, Two Weeks, April 9
Vaginal Approach to Pelvic Surgery, One Week,
December 18, Jan. 9
Obstetrics, General & Surgical, Two Weeks,
Nov. 27, March 12
Fractures & Traumatic Surgery, Two Weeks, March 5
Advances in Medicine, One Week, November 27
Practical Cystoscopy, Two Weeks, Dec. 11, Jan. 8
Proctoscopy and Sigmoidoscopy, One Week,
Dec. 18, Jan. 29
Treatment of Varicose Veins, One Week,
Dec. 18, Jan. 29
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Ambulatory Medical Admissions— What About Them?

E. T. EDWARDS, M.D.

Vincennes

WITH EVERYONE getting into the act, kicking doctors threatens to replace the national sport of baseball. It also threatens a sensible approach to the problems of financing medical care, especially the problems of insurance programs. Even we physicians succumb to the temptation of blaming each other for the high cost of medical care.

Politicians, "Blue" Directors, Economists, Insurance Commissioners and Mr. & Mrs. Public all have the answer which is that the doctors admit too many patients, order too many tests, and forget to send the patient home until all the insurance money is spent! This blaming every woe on one person or group and forgetting one's own weaknesses requires neither ability nor special equipment and is manifested every three years out of four when we have elections.

During all the furor, many areas have been investigating hospital admissions in an attempt to determine the facts. Two large studies using physician analysis have been the Michigan University team under Prof. W. J. McNerney and the Tenth Councilor District of the Pennsylvania Medical Society. Preliminary reports from Michigan indicate hospital ineffectiveness was 16.4% which is the total of 9.6% patients who stayed too long and 6.8% who left the hospital too soon to receive minimum care needed (as determined by the professional panels). The net 3% overstay is attributed to physician laxity.

In the Pittsburgh survey, questionable cases were referred by Blue Cross to local hospital

staff utilization committees. Comparisons between the first three months and the last nine months of the program were made recently. This concerned about 12% of the affected hospital's admissions during the period. The percentage of questionable cases dropped from 10% to 5% during the year and was attributed to the better understanding and effectiveness of the utilization committees. Thus the extent of the physician's influence in hospital overuse has been given a definite figure ranging from 3% to 10% which translated into dollars is admittedly a sizeable sum. But what about the remaining 90%?

Criticism of the ambulatory medical patient is most often heard. Hardly anyone dies standing up and if he was not cut on, what is he doing in the hospital? This is not an attorney's question which can be answered with a simple yes or no. When questioned, most doctors start their answer with a revealing qualification, eg.,

"If prepayment limitations were not a factor,—"

"If malpractice spectre,—"

"If the referring doctor had not already admitted the patient,—"

"If you knew your competitive colleagues would stand pat and support your refusal, possibly this patient could have been treated in the office."

Do not forget to recognize the necessity, especially for young doctors and specialists with referred patients, to prove to the patient that you are correct clinically thus requiring positive

diagnostic data and negative information to rule out or differentiate the illness from similarly appearing conditions. Social customs and economic factors in the home add to the case for admission to the hospital.

Sometimes a Detriment

The case against admission to the hospital is not merely financial, providing the above conditions can be overcome. The medical man's lot in the modern crowded hospital is neither easy nor efficient when compared to his office practice and there is some reason to believe that a hospital stay can be detrimental to the ambulatory patient. Naturally, no one will believe this statement except pediatricians, psychiatrists, internists and a few other non-cutting practitioners.

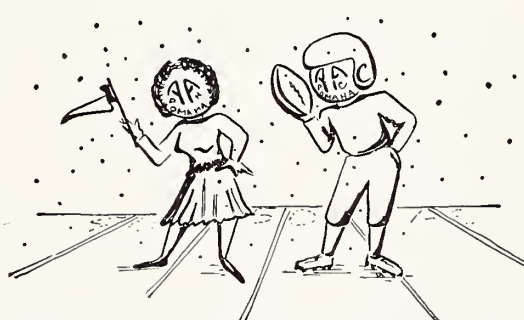
Inadequate facilities or none at all, lack of examination privacy, indifferent paramedical aides, physician's time wasted waiting for his turn at the one examination table or for someone to bring what they forgot the first trip contribute to inefficient medical hospital practice. In contrast, the doctor's office has been developed by him to provide the ideal situation for doing good work rapidly and usually at less expense for the patient. Would you want to talk about your personal problems while a stranger listened three feet away in the other bed? Did you ever skip a routine rectal or pelvic exam because you might have more time tomorrow to wait for the tray? Sure, a hospital is a wonderful place for major surgery, but how many are geared for your type of practice? The people you hire know that your patient is their important boss and they do not make the flippant remarks that offend. Much is said about the hospitals competing with local industry for labor; hence the rising labor cost. When you hire a new employee from the hospital to work in your office, do you hire the average—or the best? How many of their employees could get a job in local industry? Answers to these questions might make you think twice about the next patient you send to the hospital for a "workup".

Which Ambulatory Patient?

Which ambulatory patient should you admit to the hospital? That is your decision, doctor. Obviously, it is not feasible to have a list of do's-and-don't's for a mature professional person, but please avoid the pitfall of rationalizing all your acts in favor of having the most admissions of any medical man on your staff.

In conversations with family doctors and specialists about ambulatory patients, the functionally ill patient seems to pose the greatest problem for all of us. These insecure persons seeking an organic explanation for their ills are frequently all too willing to be admitted. They find new complaints as rapidly as normal laboratory and x-ray reports are received, thus prolonging something that should not have been started. When you advise hospitalization for these patients, you imply great concern about their illness and may augment their fears when you intended to reassure. This can make rational treatment more difficult and expensive for the patient. Of course, management of psychosomatic cases is usually tedious and hospitalization is hard to refuse when their friends with similar symptoms have been to a teaching center. Sharing such trials with the resident staff is tempting when you are busy or more interested in tissue pathology.

One might conclude that it is time for us doctors to run our practice, not the contrary. Our medical economic advice is being sought with as much interest as our clinical judgement. The future practice of medicine may depend upon whom we admit today. ◀



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Medicine

At

Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Jury Returns Verdict for Injuries at Birth—A Union County, New Jersey jury has awarded \$175,000 to a 5-year-old girl and \$75,000 to her parents for injuries she sustained at birth. The girl suffered irreparable brain damage. The judgment was against the obstetrician who delivered the child and the hospital where the child was born.

The child was full term. The delivery was normal. The parents contended that their daughter was normal and pink in color at birth. The obstetrician maintained that the child was blue. The mother contended that the labor-delivery suite was cold. The hospital said that the temperature was controlled by individual thermostats which were checked daily. The mother contended that her child was unattended for a period of 7 to 10 minutes after birth. The obstetrician said that the child was wrapped in blankets and given oxygen through a funnel and mask when her color worsened after birth. It was admitted that the infant was removed from the crib and the supplemental oxygen supply and was carried by a nurse up the stairway to the hospital nursery. In the nursery, the infant was placed in an incubator and given oxygen again. The infant appeared to be in good condition for a short time but she was placed on the critical list a few days after her birth when she exhibited symptoms of shock. The girl has been a hospital patient since 1957. The brain damage, blamed on lack of oxygen, has left her blind, deaf, unable to speak, feel, smell or taste. She

cannot feed herself and is unable to sit up, stand or walk.

The plaintiff contended that the child has a normal life expectancy but must be hospitalized for the remainder of her life.

A few hours after the child's birth her mother began a detailed record in her dairy of the events in the hospital. She kept a similar record for all of her four children, one of which was born two years after the little girl in this case, and had kept a personal diary of her own for many years.

She was on the witness stand for almost a week and based much of her testimony on the diaries.

The *Citation* has been informed that an appeal is planned in this case.—*Lewis v. Read, St. Barnabas Hosp., et al.*, Union County District Court, N.J., (July 14, 1961).

Colorado Chiropractors Challenge State Law Prohibiting their Treatment of Cancer Victims—Colorado chiropractors have filed a test case claiming that a new state law prohibiting their treatment of cancer victims is unconstitutional. They asked the court to declare the law invalid.

The Colorado Legislature last April passed a so-called "cancer quack" bill which banned chiropractors from "treating or prescribing for the treatment of cancer" and requiring them to refer all cancer patients to an M.D. or an osteopath.

The Colorado Chiropractic Association in its test suit in Denver against the state government and the state's new Cancer Advisory Council

claims that the law not only violates the rights of chiropractors but also deprives the public of its "right of election of remedies and methods of treatment."

Sponsors of the new law contended that it would curtail, if not eliminate, phony, would-be cures and medicines in the field of cancer. Chiropractors, including a state senator, Neal Bishop, charged that it was a "conspiracy to exterminate our profession."

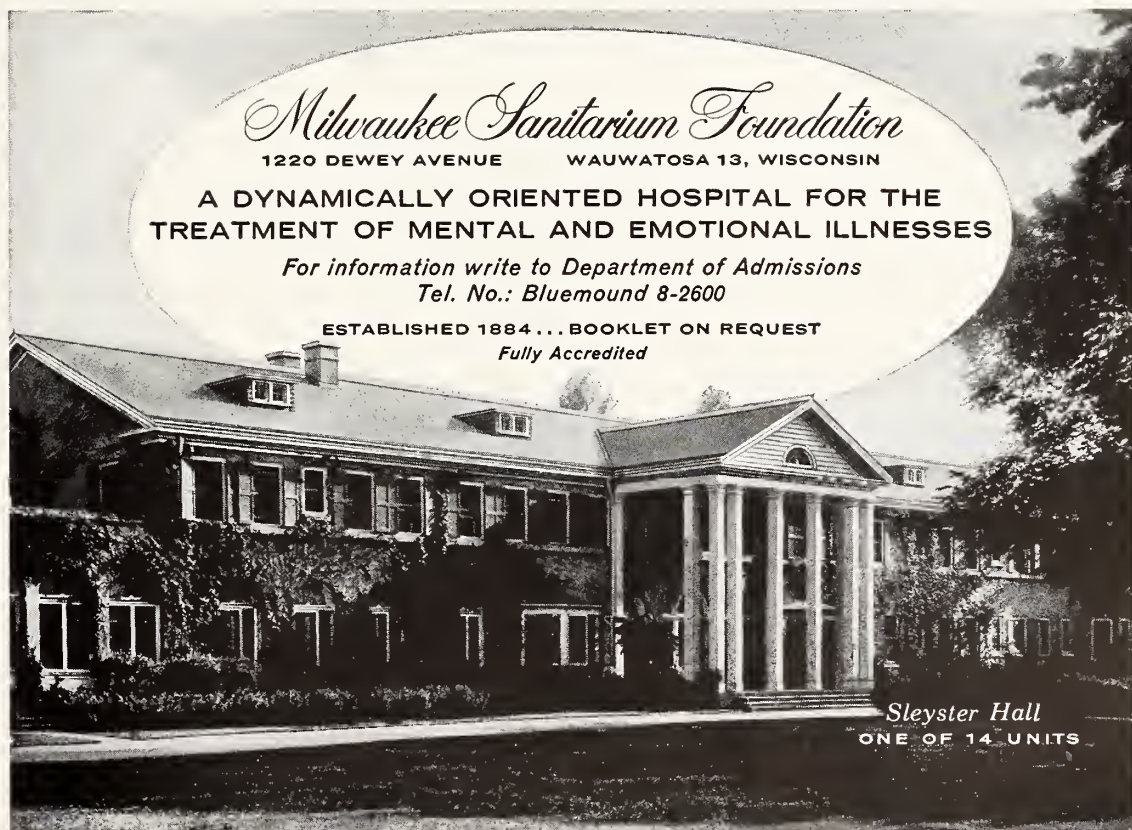
New Trial Ordered on Question of Brain Damage During Childbirth—A damage suit against a physician, charging that his negligence during delivery had caused brain damage to an infant, should have been submitted to the jury. An intermediate appellate court in California held that a nonsuit was improperly granted.

The mother testified that she had been taken into the delivery room although a nurse had reported that the cervix of the uterus had not been completely dilated. She said that the attending physician, and, at his direction, two nurses and an anesthetist had pushed down on her stomach vigorously. A pediatrician testified that he had examined the child shortly after its birth and found it to be suffering cephalhematoma (a sep-

aration of the membrane covering the skull from the skull proper). He said that this was not a congenital anomaly, but was due to pressure upon the skull during delivery. An osteopath testified that the mother's pelvis was normal and that it was his opinion that the brain damage was caused by the pressure exerted on the mother's abdomen during delivery.

The attending physician testified that he had noticed no abnormalities of the mother that might contribute to an abnormal birth, that there was no evidence of injury to the mother during the pregnancy, that it was not good practice to force a child out by pressure on the abdomen, and that if a crushing type of injury were great enough it could squeeze the brain and cause the condition from which the child was suffering.

The appellate court held that a nonsuit should not have been granted by the trial court. It said that nonsuit should be denied if there is any substantial evidence which, with the aid of all legitimate inferences favorable to the plaintiff, tends to establish the averments of the complaint. The case was remanded to the trial court for a new trial.—*Libby v. Conway*, 13 Cal. Rptr. 830 (Cal., June 12, 1961). ◀



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ABSTRACTS

BOOK REVIEWS

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION

John J. Hanlon, M.S., M.D., M.P.H. 3rd Edition, C. V. Mosby Co., St. Louis—Price \$10.50 pages 714—1960.

As a part time physician to a County Health Department I find this an interesting and handy reference book. The volume is divided into four parts and in Part one—covers "Philosophy and Development of Public Health."

Part two entitled "Administrative Consideration in Public Health" deals with the legal governments, fiscal, organizational, personnel and public relation aspects of Public Health. Each of the above topics are exceedingly well covered.

The chapter on "Public Relations" seem to me to be outstanding because of the necessity of having public support for a well functioning department. A quote discussing public relations is apropos: "Public Relations is not an ambulance parked at the bottom of a precipice. Rather it is a fence built at the top." Our population explosion and the complexity of our civilization makes Public Health a must for the benefit of the many. The volume brings out the many facets of Public Health and how foreign they all are to the average practicing physician.

Part three—"Pattern of Public Health Activities in the United States." This might be termed the working basis of Public Health and covers organizations, vital statistics, laboratory services, maternal and child health, nursing, health education, nutrition, occupational health, mental health, communicable diseases, accidents and rehabilitation to mention a few. The author brings out the interdependent relationship of the Health Office and the private practitioners.

The Chapter on "Control of Communicable Diseases" is quite detailed on the methods and problems entailed in their control and eradication.

Part four deals with the "Future of Public Health." Here the author brings the past, the present, and what can be expected in the future, into sharp focus.

A volume well worth reading and a handy reference work for the Health Officer.

W. L. Portteus, M.D.
Franklin

Abstracts From Various
Literature, Prepared by AMA

PORPHYRIA, DIABETES, AND THEIR RELATIONSHIP

The literature reveals an increased incidence of diabetes (25%) among men with porphyria. This has not been demonstrated in women, nor is there a similar increased incidence of porphyria among diabetics. The associated abnormality of iron metabolism in porphyria is often accompanied by hemochromatosis. Porphyria may produce diabetes by two mechanisms, both a result of failure of iron incorporation into the tetra-pyrrole ring: (1) excessive iron accumulation leading to hemochromatosis, with damage to parenchymatous cells of the liver and pancreas and associated skin pigmentation; (2) parenchymatous cellular dysfunction due to deficiency of vital metabolic enzymes containing the iron protoporphyrin prosthetic groups. A male patient with porphyria cutanea tarda developed diabetes mellitus four years after the onset of cutaneous symptoms. The striking, bluish-grey tint of the skin and increased iron in the bone marrow were thought to represent early hemochromatosis. It is conceivable that chelation, which has been reported to be effective in porphyria, may also reverse diabetes mellitus secondary to the disturbance of porphyrin metabolism, when the latter is corrected.

Burnham, T. K., Fosnaugh, R. P.: Porphyria, Diabetes, and Their Relationship, *Archives of Dermatology* 83:717, May, 1961.

TREATMENT OF MALIGNANT TROPHOBLASTIC GROWTH IN WOMEN

Six women with metastatic choriocarcinoma have been treated with amethopterin at the Roswell Park Memorial Institute. Two of these are alive and free from detectable disease 37 and 24 months later. One patient with hydatidiform mole and pulmonary metastases is alive and free from detectable disease 19 months later. Amethopterin, mechlorethamine oxide hydrochloride and radiation are all effective against lung metastases in invasive mole. Amethopterin appears to be the most effective agent in the treatment of patients with metastatic trophoblastic neoplasms.

Hreshchyshyn, M. M., Graham, J. B., Holland, J. F.: Treatment of Malignant Trophoblastic Growth in Women, With Special Reference to Amethopterin. *Am.J.Ob. and Gyn.* 81:688, April, 1961.

VALUE OF SURGICAL REMOVAL OF LOCALIZED LYMPHOMAS

The records of 54 patients with localized lymphoma were reviewed. Thirty-one patients were treated by surgical removal of the area involved, and 23 were treated by roentgenotherapy alone. Both groups were comparable as to age, location of the disease, operability and histological types. Those treated by roentgenotherapy only received tumor doses ranging from 1,760 to 14,000 r, with an average of 3,535 r and a median dose of 3,000 r. Of the 31 patients treated surgically, 22 were living well when this article was written, as compared with two of the 23 treated by ro-



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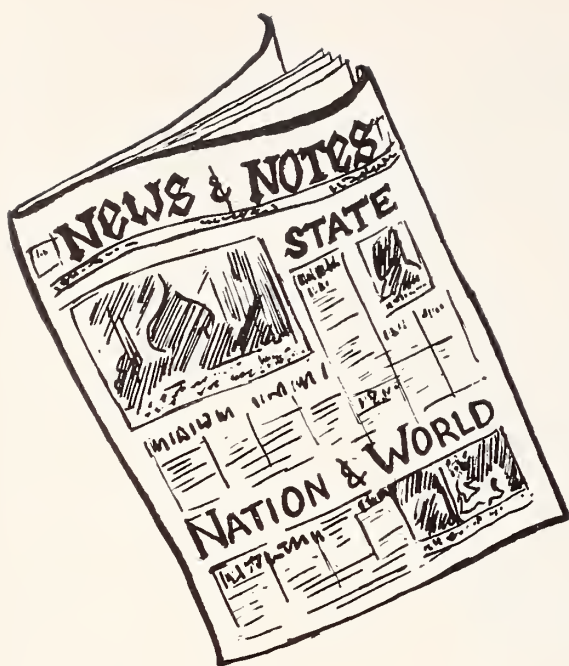
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agranulocytosis
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Terre Haute Pathologist Honored At National Meeting

Dr. Leon L. Blum of Terre Haute was awarded the Achievement Award of the Private Practitioners of Pathology Foundation on October 4 in Seattle, at the annual meetings of the College of American Pathologists and the American Society of Clinical Pathologists. The award is given annually to an outstanding pathologist in private practice. The first award was given last year to Dr. May Owen of Texas who is also distinguished by having served as president of the Texas Medical Association.

Highlights of AMA New York Meeting Featured in Schering Film

Medifilm Report III, presenting highlights of the American Medical Association's 110th Annual Meeting in New York City, has been made available to medical and allied groups by Schering Corporation, in cooperation with the AMA Department of Medical Motion Pictures and Television.

The 33-minute, 16 mm. black and white sound film features scientific exhibits, lectures and panel discussions. Host-narrator is Jeff J. Coletti, M.D., of Old Westbury, N. Y. Interested state and county medical societies may obtain a copy of Medifilm Report III by writing to the American Medical Association, 535

North Dearborn Street, Chicago 10, Ill., or to the Audio-Visual Department, Schering Corporation, Union, N. J.

Of special interest is a demonstration of external cardiac massage at the 1961 Gold Medal Award exhibit manned by Guy Knickerbocker and W. B. Kouwenhoven, both of Baltimore. A mannikin is used to show the actual technic of closed chest cardiac massage.

Other subjects covered are office management of varicose veins (William Foley, M.D., New York, N. Y.); electrical anesthesia (James H. Hardy, M.D., Jackson, Miss.); new concepts in diabetes (Howard Root, M.D., Boston, Mass.); rubella in pregnancy (Frank Lock, M.D., Winston-Salem, N. C.); polycystic ovaries (Robert Greenblatt, M.D., Augusta, Ga.); the anxious out-patient (Jackson Smith, M.D., Chicago, Ill.); allergic reactions to drugs (Giles A. Koelsche, M.D., Minneapolis, Minn., and panel members); cine coronary arteriography (F. Mason Sones Jr., M.D., Cleveland, Ohio); and part time medical mission work (Archibald Fletcher, M.D., India and Glendale, Calif.).

In conclusion, Dr. E. Vincent Askey, outgoing AMA president, speaks on the theme of the 1961 convention—teamwork in medicine.

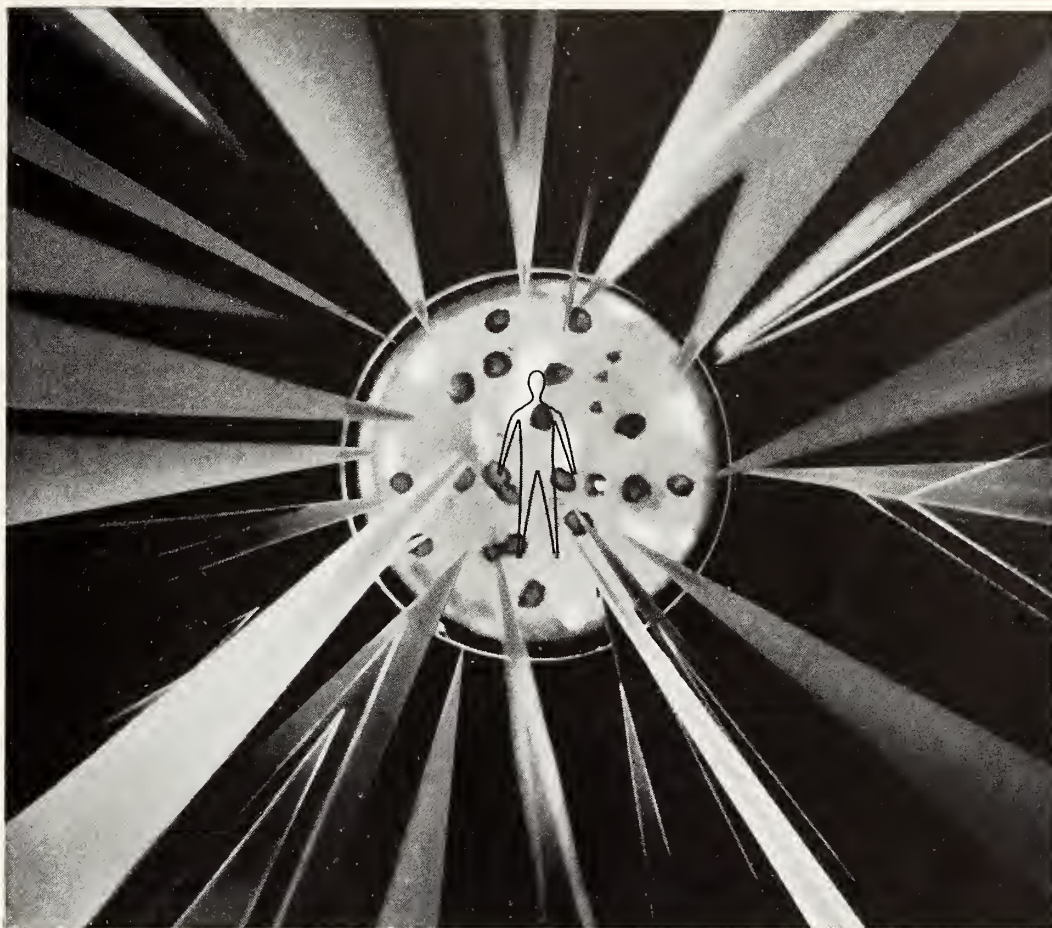
Pfizer Offers New Film On Oral Polio Vaccine

Pfizer Laboratories, with the cooperation of the AMA, is making available to medical societies their 16 mm. black and white, sound motion picture on oral polio vaccine. The film is titled "The Next Step." It was shown at the recent New York AMA meeting and is now available for small groups. Requests should be sent to Chas. Pfizer & Co., 235 E. 42nd St., New York 17, at least three weeks in advance, and with at least two later alternate dates. If the size of the expected audience is indicated in the request a supply of Supplemental Notes for distribution to the viewers will be sent also.

Doan Named Deputy Surgeon General

Howard W. Doan, presently Brigadier General, Medical Corps of the Army, who was Surgeon of Camp Atterbury and Commander of the Atterbury Army Hospital immediately after World War II, has recently been designated as Deputy Surgeon General. He succeeds Major General T. J. Hartford who retired on September 30.

Continued



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NEWS NOTES

Continued

Anti-Malaria Pill Available To Armed Services Now

A new anti-malaria pill developed by the Army Medical Service has been successfully field tested in Korea and will be available as a standard item to the Armed Forces this November.

A combination of chloroquine and primaquine, the pill is the result of studies conducted by Dr. Alf S. Alving of the University of Chicago under contract with the U. S. Army Medical Research and Development Command, Washington, D. C.

Malaria prevention is simplified by the combined tablet. Formerly chloroquine was administered in weekly dosages to patients in malarious areas followed by a dosage of primaquine for 14 consecutive days upon leaving the area.

The 14 days of primaquine treatment was given during the return trip to the United States from the Far East. With increased use of air transportation this 2-week time was no longer available for proper administration of the drug.

The new pill is as efficacious as the old method and is a real timesaver, since it is only taken once a week while in the malarious area. Under the old system with rapid transportation, it would have been necessary to arrange medical surveillance of patients for two weeks after returning to the United States.

Alternatives were to detain personnel at one or the other of the terminals—Korea or the United States—for 2 weeks medical surveillance during treatment.

An additional improvement in the new tablet is the development of a coating which disguises its very bitter taste. This had been an objectionable feature of both the old chloroquine tablet and the first of the new combined chloroquine-primaquine tablets.

EXILED CUBAN PHYSICIANS OFFERED AMA AID

The American Medical Association has taken affirmative steps toward assisting the 1,200 refugee Cuban physicians who have fled the Castro regime.

As approved by AMA's Board of Trustees, the steps include:

—An appropriation of a sum of \$1,000 a month for a period of six months for the establishment of an office for the exiled group at Coral Gables, Fla. The AMA stipulated that the money was not to be used for propaganda purposes.

—The urging of American physicians to absorb the exiles into their practice under a preceptorship program where the Cuban doctor could receive appropriate training in order to eventually qualify for licensing under the programs sponsored by the Educational Council for Foreign Medical Graduates.

—The expansion of job placement programs by voluntary agencies particularly where the passage of the Educational Council test is not required.

—Recognition of the Cuban Medical Association in Exile as representing the refugee physicians.

—In taking the policy action, the AMA Trustees studied the proposals from AMA's Committee to Consider Problems of Foreign Physicians which, with members of AMA's Department of International Health had met earlier in Miami with representatives of the Cuban group.

Several Hoosier Medics Inducted as Fellows by College of Surgeons

At a recent Clinical Congress in Chicago, 1103 surgeons were inducted as Fellows of the American College of Surgeons. Surgeons from Indiana thus honored were Dr. William R. Kopp, Anderson; Drs. Irwin T. Rieger and Joseph F. Milan, Bloomington; Dr. Zbigniew Sobol, Elkhart; Dr. Ben K. Harned, Jr., Evansville; Drs. J. Robert Ball, Luman W. Bromley, Philip G. Hershberger, Elfred H. Lampe, Michael J. Mastrangelo, Philip L. Smith and August Tomusk, Fort Wayne; Drs. Paul F. Benedict, John E. Mackey and Harry Siderys, Indianapolis; Dr. Seth S. Philbrook, LaPorte; Dr. Ralph O. Butz, Jr., Muncie, and Dr. Robert L. Parsons, South Bend.

Allergists Schedule Spring Congress

The American College of Allergists Graduate Instructional Course and 18th annual Congress is scheduled April 1-6, 1962 at the Hotel Radisson, Minneapolis, Minn. Further information may be obtained from Dr. John D. Gillaspie, Treasurer, 2141 14th St., Boulder, Colo.

Continued on page 1724

County News

Allen

"What Would You Do, Doctor?" was the talk given by Dr. Gamber F. Tegtmeier at the Oct. 3 meeting of the Allen County Medical Society. There were 107 physicians present.

Bartholomew-Brown

Thirty-three members of the Bartholomew-Brown Medical Society met at Columbus, Sept. 13. Dr. R. M. Seibel presented a film on civil defense, and a legislative discussion followed.

Benton

Five members of the Benton County Medical Society met at Fowler Sept. 29 for a business meeting.

Cass

Dr. James Kubley spoke at a meeting of the Cass County Medical Society Sept. 11 at Logansport. Sixteen members attended.

Clinton

Thirteen members of the Clinton County Medical Society met at Frankfort for a business meeting, Sept. 26.

Dearborn-Ohio

Dr. Jose Ibanez, Cincinnati, spoke on "Pyelonephritis" at the Sept. 14 meeting of the Dearborn-Ohio Medical Society. The nine members present also held a business meeting and legislative discussion.

Decatur

Representatives of Indiana voluntary health agencies spoke to 10 members of the Decatur County Medical Society at their monthly meeting, Sept. 19 in Greensburg.

Fountain-Warren

Members of the Fountain-Warren Medical Society made plans for a November Road Show at their meeting in Attica, Sept. 7.

Howard

Thirty members of the Howard County Medical Society met Sept. 5 at Kokomo to view a film on polio vaccine and to initiate plans for medical assistant workshops and future physicians clubs during the coming year.

Hendricks

Sixteen members of the Hendricks County Medical Society met at Danville Sept. 12 for a business meeting.

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Huntington

Dr. W. D. Griest, Fort Wayne, spoke on the organization of the pathology department of Huntington County Hospital at the Sept. 12 meeting of the Huntington County Medical Society at Huntington. Twenty members attended.

Jefferson-Switzerland

Twenty-two members of the Jefferson-Switzerland Medical Society met Sept. 12 for a business meeting.

Lawrence

Twenty members of the Lawrence County Medical Society held a business meeting at Bedford on Oct. 4.

LaPorte

Dr. Peter Moulder, Assistant Chief of Surgery, University of Chicago Clinic, spoke on "Modern Surgical Trends" at the Sept. 19 meeting of the LaPorte County Medical Society.

Marion

Members of the Marion County Medical Society heard an address by Phil Brown, Indianapolis native, now with operations staff of General Dynamics Astronautics at Cape Canaveral, at their Oct. 2 meeting.

Montgomery

Dr. William B. Ferguson, Lafayette, discussed Athletic Injuries at a meeting of the Montgomery County Medical Society Sept. 21 at Crawfordsville. Twenty-five coaches, representing local schools, were guests.

Owen-Monroe

Thirty-five members of the Owen-Monroe Medical Society saw a Wyeth film on "Management of Peptic Ulcer" at their Sept. 28 meeting, and also listened to a presentation by the local United Fund.

Rush

Members of the Rush County Medical Society had as their speakers at a Sept. 14 meeting representatives of local voluntary health agencies, who gave talks on their respective organizations.

Tippecanoe

Newly-elected officers of the Tippecanoe County Medical Society are Drs. Harley H. Frey, president; F. J. Babb, vice president; J. J. Onorato, secretary; W. R. VanDenBosch, treasurer; R. B. DuBois and Dr. Babb, delegates, and Dr. R. W. Vermilya, alternate delegate. ◀

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Association News

EXECUTIVE COMMITTEE

August 23, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.

Frank B. Ramsey, M.D.; John Price, attorney, and James A. Waggener, executive secretary.

Guests: Guy A. Spring, Executive Director, Blue Cross
James Herod, Assistant Director, Blue Cross
Kenneth Fly, Assistant Director, Blue Cross
Council Liaison Committee with Blue Shield:

William B. Challman, M.D., chairman

John M. Paris, M.D.

Kenneth O. Neumann, M.D.

Edward T. Edwards, M.D.

Membership Report

Number of members as of Dec. 31, 1960-----4,309
1961 members as of July 31, 1961:

Full dues paying -----3,648

Residents and interns ----- 194

Council remitted ----- 40

Senior ----- 376

Honorary ----- 3

Military ----- 37

Total 1961 members as of July 31, 1961-----4,298

Gain over last year----- 32

Number of members as of July 31, 1960-----4,266

Number of AMA members as of July 31, 1960 4,130

1961 AMA members: Dues paying-----3,524

Exempt but active 654

Total 1961 AMA members as of July 31, 1961 4,178

Gain over last year----- 48

Number who have paid state dues but not

AMA dues for 1961 ----- 120

Building Committee

On motion of Drs. Glock and Stimson the Executive Committee voted to continue support of the Building Committee and that the Building Committee be authorized to accept an alternate bid on the construction of the headquarters building. This action also included an agreement that the Executive Committee would adopt another resolution giving the Building Committee a free hand to negotiate with other contractors for the construction of the building if the committee was unable to come to terms with Thomas A. Berling and Sons, Inc.

Treasurer's Office

The statements of Income and Expenses and Budget Balances as of July 31, 1961, for the headquarters office, *Journal*, Building Fund, and all funds of the Association, were reviewed and approved by consent.

Legislative Matters

The chairman of the Commission on Legislation reported on the letter received from Dr. Joseph Davis dealing with the corporate practice legislation. This was handled as a matter of information only.

Organization Matters

Health Careers, Inc. A request for a contribution of \$1,000.00 from Indiana Health Careers, Inc. was tabled on motion of Drs. Glock and Owsley.

A letter was read from Mrs. Burton E. Kintner asking if the Executive Committee would concur in the State Woman's Auxiliary using \$50.00 of the money appropriated by the Association for a gift from the Auxiliary to the Indiana Chapter of the Student AMA Auxiliary. Upon motion of Drs. Stimson and Owsley Mrs. Kintner is to be informed that this would not be acceptable to the Association.

A note of thanks from the Don E. Wood family was acknowledged by the Committee.

A letter and resolution from the Medical Association of Georgia, urging the component associations and members of the AMA to go on record by public advertisement, if necessary, to inform the public that the respective associations and members are behind the AMA and the AMA does represent them in legislative activities were read. Upon motion of Drs. Glock and Stimson this letter and resolution are to be referred to the Council.

1961 Annual Convention, Indianapolis, Oct. 23, 24, 25 and 26, 1961

Sale of exhibit space was noted and approved by consent.

Future Meetings

Congress on Medical Quackery, AMA, Washington, D. C., Oct. 6-7, 1961. No action was taken upon motion of Drs. Glock and Owsley.

10th Annual meeting, U. S. Civil Defense Council, Los Angeles, Oct. 16-20, 1961. On motion of Drs. Glock and Owsley it was decided Indiana would not send a representative to this meeting.

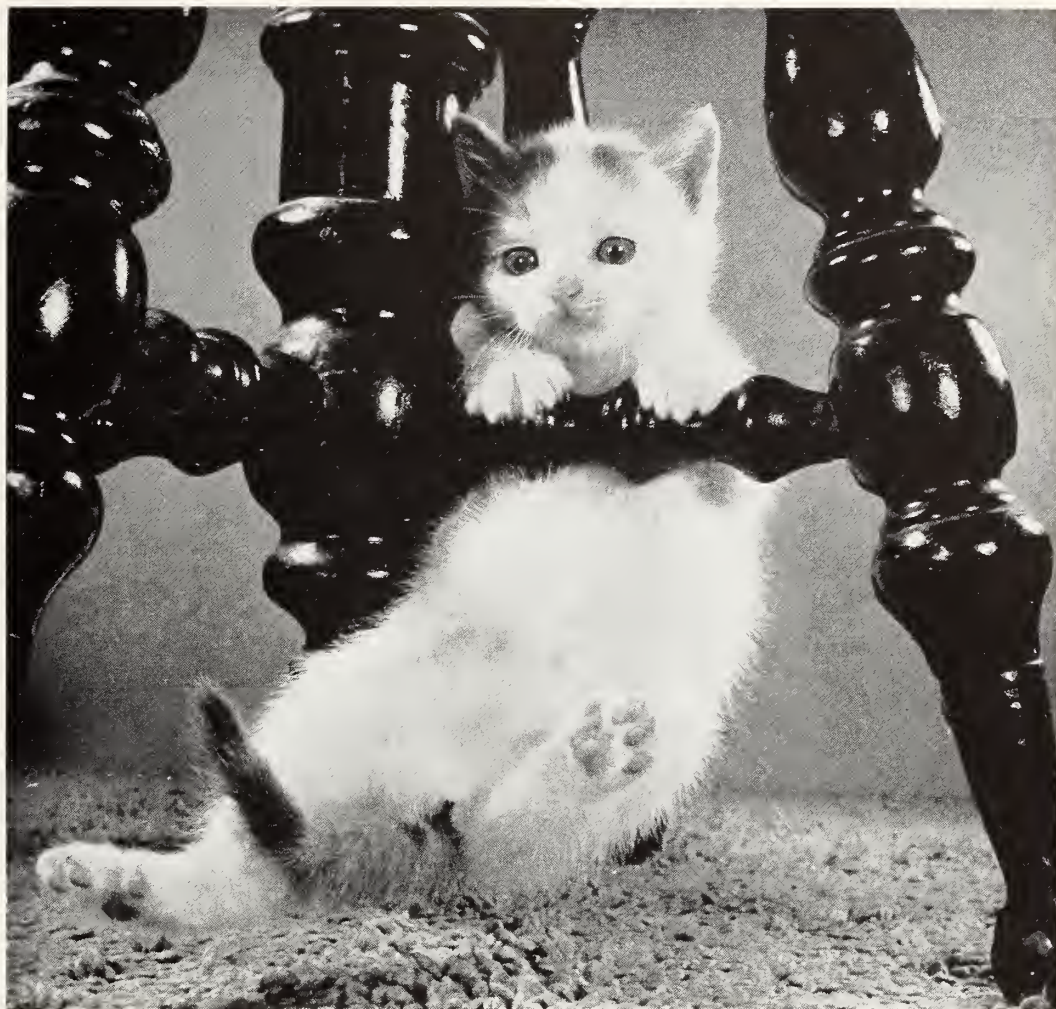
Annual Conference on Mental Health, Feb. 2 and 3, 1962, Chicago. It was agreed and taken by consent that a representative of the Commission on Governmental Medical Services should represent the Association at this meeting.

Blue Cross Reconfirmation Policy

Mr. Guy A. Spring, executive director of Blue Cross Hospital Service, Mr. James Herod and Mr. Kenneth Fly, assistant directors, appeared before the Executive Committee, as did Dr. William B. Challman, chairman of the Liaison Committee between the Council and Blue Shield, with other members of his committee, including Drs. John M. Paris, Kenneth O. Neumann, and Edward T. Edwards, for the purpose of discussing the recent action taken by the Blue Cross Board in instituting a 15-day reconfirmation procedure in Indiana.

In opening the discussion Dr. Wood, chairman of the Executive Committee, read the letter sent by the headquarters office to Mr. Spring under date of July 13, 1961, outlining the action of the Council taken at its meeting on July 9, 1961, and dealing with the subject under discussion.

Mr. Spring was then called upon to outline the Blue Cross policy and to review, for the information of the



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Executive Committee, the events leading up to the formation of the Blue Cross Plan in Indiana in 1944.

Mr. Spring reviewed the Constitution and Bylaws of the Blue Cross Plan, known as Mutual Hospital Insurance, Inc., as originally adopted on July 6, 1944. Under this document the Blue Cross Plan was to have a Medical Committee of five members, who were to be named by the Indiana State Medical Association. Mr. Spring stated that in discussing this with Mr. Thomas A. Hendricks, then executive secretary of the Indiana State Medical Association, Mr. Hendricks stated the Association would refuse to participate in the naming of these individuals. Subsequently, Mr. Spring stated, the Constitution and Bylaws were amended, but the date of this amendment was not available at the time of the meeting. The Bylaws as amended now read that there shall be five (5) physicians as members of the Board of Directors of Blue Cross and that these five doctors shall constitute a Professional Advisory Committee. The Bylaws under Article VIII, Section 3, read as follows:

3. **Professional Advisory Committee.** There shall be a Professional Advisory Committee, consisting of not less than five physicians. This Committee shall be appointed by the President of the Corporation, following consultation with the Indiana State Medical Association. Any three members shall constitute a quorum. The duties of this Committee shall be to advise with the Executive Director and the Board of Directors, concerning all medical problems that may arise in carrying out the purpose of this corporation; and to perform such other duties as may be requested of it by the Executive Director.

Dr. Stimson then raised the question concerning the appointment of these medical representatives, referring to correspondence from Dr. Wemple Dodds and others who were active in the formation of the Blue Cross Plan. Mr. Spring reviewed then in more detail the formation of the Medical Committee and the composition of the Blue Cross Board.

It was agreed that the Blue Cross Plan had not formally implemented this provision. Mr. Spring readily agreed that in the future he would make a formal request for participation of the Association as provided for in the above section.

It was then brought up for discussion the matter of the institution of the reconfirmation policy established by the Blue Cross Plan. Mr. Spring pointed out that the Blue Cross certificate gave the Plan the right to deny payment of hospital care for unnecessary stays and that during the first four weeks of operation of this plan 1841 forms had been received and he had received letters from physicians, some of whom approved of the idea instituted by Blue Cross, while others were critical.

Dr. Challman then asked for a review of the form being used by the Blue Cross Plan. Mr. Spring answered by stating that the Indiana Plan had originally adopted a form currently being used in Illinois but they had revised the form in view of some of the criticism of the length and information contained upon

the form and presented an abbreviated form which the Plan proposed to use.

Dr. Challman then asked who in the Blue Cross organization would make the determination as to whether or not a patient stayed in the hospital at Blue Cross expense too long or too short a period of time. Mr. Spring stated that the Medical Committee, in all cases, would make the evaluation and in no instance would any of the lay staff of the Blue Cross Plan attempt to adjudicate the doctor's request for increased length of stay.

Discussion then arose regarding some correspondence which had been received by patients and doctors from staff members of the Blue Cross Plan and quite a discussion took place on who in the Blue Cross organization would make a determination as to which of these requests would be referred to the Medical Committee. Mr. Spring stated that all requests of doctors would be referred to the Medical Committee.

Mr. Spring stated that normally the staff of Blue Cross made the determination as to whether or not Blue Cross had the liability of payment for hospital care in three primary areas: (1) payment of membership fee by the member; (2) admission for purely diagnostic purposes, and (3) for the hospitalization for pre-existing conditions as excluded in their contracts.

Mr. Spring further pointed out that the Medical Advisory Committee handles all correspondence from physicians who might have a complaint against the Blue Cross Plan.

Dr. Paris then read sub-paragraph 2 of the letter dated June 15, addressed to all doctors from the Blue Cross Plan and also called attention to an item on next to the last page of the booklet called "Selling," which was distributed at the Blue Shield Board meeting. It seemed that the item contained in the letter and the one contained in the book were in conflict with each other and Dr. Paris asked which of the statements was correct. Mr. Spring stated that the item contained in his letter was the correct version.

Dr. Challman then pointed out that the statement was previously made that the Board had studied hospital rates and inquired as to how the increase of hospital rates was handled. Mr. Spring stated that since the beginning it had been necessary for hospitals to request approval of the Blue Cross Plan before increasing the room rates and hospital charges. They have since established a review committee which has been in operation for about a year and a half, or two years, which thoroughly analyzes all hospital costs before accepting increased rates from the hospitals. The question was then asked if the Blue Cross Plan had ever refused to accept increased rates from the hospitals. Mr. Spring replied that this had been done.

The Committee then came back to the Professional Advisory Committee, asking the method Mr. Spring would recommend as to implementing the provisions of the Bylaws. Mr. Spring stated that he felt that the procedure should be formalized in writing and not be a matter of verbal conversation and that he would

make such a recommendation to the Blue Cross Board at its next meeting.

The question was then asked as to term of office of the president and other members of the Board. Mr. Spring replied that the current president of the Blue Cross Board is Lloyd D. Claycombe. His term of office is for one year and he is elected annually by the Board. He further pointed out that the Medical Advisory Board members are elected annually.

Mr. Spring further explained that the Hospital Advisory Committee was also appointed annually and was constituted by members of the Board of Trustees of the Indiana Hospital Association.

Mr. Spring was then asked if the Board of Blue Cross had ever considered employing a physician to review the statements of physicians regarding treatment given. Mr. Spring answered they had not.

The Committee next discussed preparation of a letter to the Blue Cross Board concerning the nomination of members for the Blue Cross Medical Committee representing the Indiana State Medical Association. It was then taken by consent that the Executive Committee would prepare such a letter.

Dr. Owsley then asked Mr. Spring "if the reconfirmation procedure instituted by Blue Cross is basically your interest in reducing your deficit in the Blue Cross plan or in reducing the overall cost of hospital care?" Mr. Spring replied that it was his hope that this plan would accomplish both.

The question was then raised as to how Blue Cross operated its membership fee structure and Mr. Spring explained the rate formula, which is in use by groups and which has been approved by the State Insurance Commissioner.

Mr. Spring pointed out that the formula rating plan dealt with all except what is known as the "direct-pay group" and in the contract covering these individuals the contract includes an escalator clause which permits

the plan to adjust the membership fee on the basis of utilization experience.

The committee then discussed the question of transfer of professional services from the Blue Cross to the Blue Shield certificate. Mr. Spring traced the history of this and indicated to the committee that the Blue Cross Plan had no objection to the transfer of these services to the Blue Shield Plan if the transfer could be worked out satisfactorily to all concerned.

Mr. Spring then was asked the question if he would be willing to participate along with the Health Insurance Council of the State of Indiana, the Hospital Association, the Medical Association, and other groups having an interest in hospital care costs, to participate in a joint study, to discuss the total problem of increased hospital costs. It was pointed out to Mr. Spring that it was the feeling of the Committee that any release dealing with this subject should be made jointly by the groups involved and not by any individual groups.

Mr. Spring stated that they would welcome the opportunity of working with others in making a study of hospital utilization and costs.

Mr. Spring further pointed out that if the plan that they proposed did not accomplish the results they intended, or did not prove workable, that the Plan itself would be the first to advocate its withdrawal.

On motion of Dr. Glock, seconded by Dr. Stimson, the matter of the establishment of a joint study committee is to be referred to the Council.

The Committee informed Mr. Spring that he was always welcome to request an appearance before the Executive Committee, the Council, or the Commission on Insurance at any time that he had matters which he felt he should discuss with the State Medical Association.

There being no further business the Committee adjourned to meet at 6:00 p.m., Wednesday, Sept. 13, 1961. ◀

EXECUTIVE COMMITTEE

September 16, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of Dec. 31, 1960.....	4,309
1961 members as of Aug. 31, 1961:	
Full dues paying	3,654
Residents and interns	196
Council remitted	40
Senior	376
Honorary	3
Military	37
	4,306
Total 1961 members as of Aug. 31, 1961.....	4,270
Gain over last year.....	36

Number of AMA members as of	
Aug. 31, 1960	4,134
1961 AMA members:	
Dues paying	3,528
Exempt but active	656
Total 1961 AMA members as of	
July 31, 1961.....	4,184
Gain over last year.....	50
Number who have paid state dues but not	
AMA dues for 1961	122

Building Committee

The executive secretary reported on several financial matters dealing with the building and informed the committee that the contractor stated it would be possible to conduct a cornerstone laying ceremony during the time of the annual meeting. It was taken by consent that such ceremony would be held at noon on Thursday, Oct. 26, 1961. Upon motion of Drs. Stimson and Covalt the secretary was instructed to send a formal

invitation to all members of the Association to attend this ceremony.

The secretary called attention of the committee to the fact that he had been informed that steel prices would be advanced and it had been suggested that any steel furniture that might be needed for the new building should be ordered at this time to save the advance in cost. After discussion, on motions of Drs. Stimson and Glock, action was deferred.

Treasurer's Office

The treasurer presented the Statements of Income and Expenses and Budget balances as of Aug. 31, 1961, which were approved by consent.

Dr. Ramsey discussed several matters pertinent to *The Journal* and stated that he would like to conduct an essay contest again and would like to again be permitted to award up to \$225.00 in prizes. Upon motion of Drs. Wilkens and Glock the sum of \$225.00 was appropriated for this purpose.

Legislative Matters

The co-chairman of the Commission on Legislation discussed the resolution which is to come before the forthcoming meeting of the Disciples of Christ.

It was reported that the Governor will sponsor legislation in the 1963 session of the General Assembly to consolidate all of the professional licensing boards into one department and under one director.

The question of the Association paying for subscriptions to *Today's Health*, to be sent to all members of the General Assembly, was discussed, and it was reported that such subscriptions would cost \$1.50 each. On motion of Drs. Glock and Covalt, the Association is to pay the subscription fee.

Organization Matters

Blue Cross. The secretary read the letter which he had addressed to Mr. Guy Spring under date of Aug. 25 concerning the action taken by the Executive Committee and read Mr. Spring's reply for the information of the Committee.

Health Careers, Inc. Another communication from Indiana Health Careers, Inc. was read to the Committee and upon motion of Drs. Glock and Wood, this matter was to be referred to the appropriate commission for study and recommendation.

A letter from Mrs. Evelyn Montgomery, president of the Indiana State Association of Medical Assistants requesting financial assistance from the State Medical Association to help the Indiana Chapter defray national meeting expenses was read and by consent it was decided the Association would not participate financially.

1961 Annual Convention

The sale of exhibit space was noted and the final program was reviewed and approved by consent.

New Business

A copy of a letter from the Indiana Pharmaceutical Association, addressed to Mr. Arthur Loftin, secretary, Marion County Medical Society, concerning a new prescription plan being started by an Indianapolis drug store, was read for the information of the Committee.

Dr. Glock commented on the testimony which was prepared by Dr. Wood for presentation to the House Ways and Means Committee on H. R. 4222 and moved that Dr. Wood be commended highly for the content of this presentation as it was well prepared and that the article should be published in full in *The Journal*. Seconded by Dr. Stimson and carried.

Future Meetings

On motion of Drs. Glock and Stimson, Dr. Wood and the secretary were authorized to attend the President's Conference on Public Affairs to be held in St. Louis on Oct. 10.

By consent it was agreed to send one representative to the Second National Congress on Prepaid Health Insurance, to be held in Chicago on Oct. 14 and 15, 1961. Dr. Lowell I. Thomas, chairman of the Commission on Medical Economics and Insurance, or possibly Dr. E. T. Edwards, might represent the Association at this meeting. The secretary was to contact the Marion County Medical Society to determine if that society intended to send a representative, and if so, would it be Dr. Thomas.

An invitation to participate in the Public Affairs Conference of the United States Chamber of Commerce, to be held in Washington, D. C., on Jan. 24 and 25, 1962, is to be discussed at the next meeting.

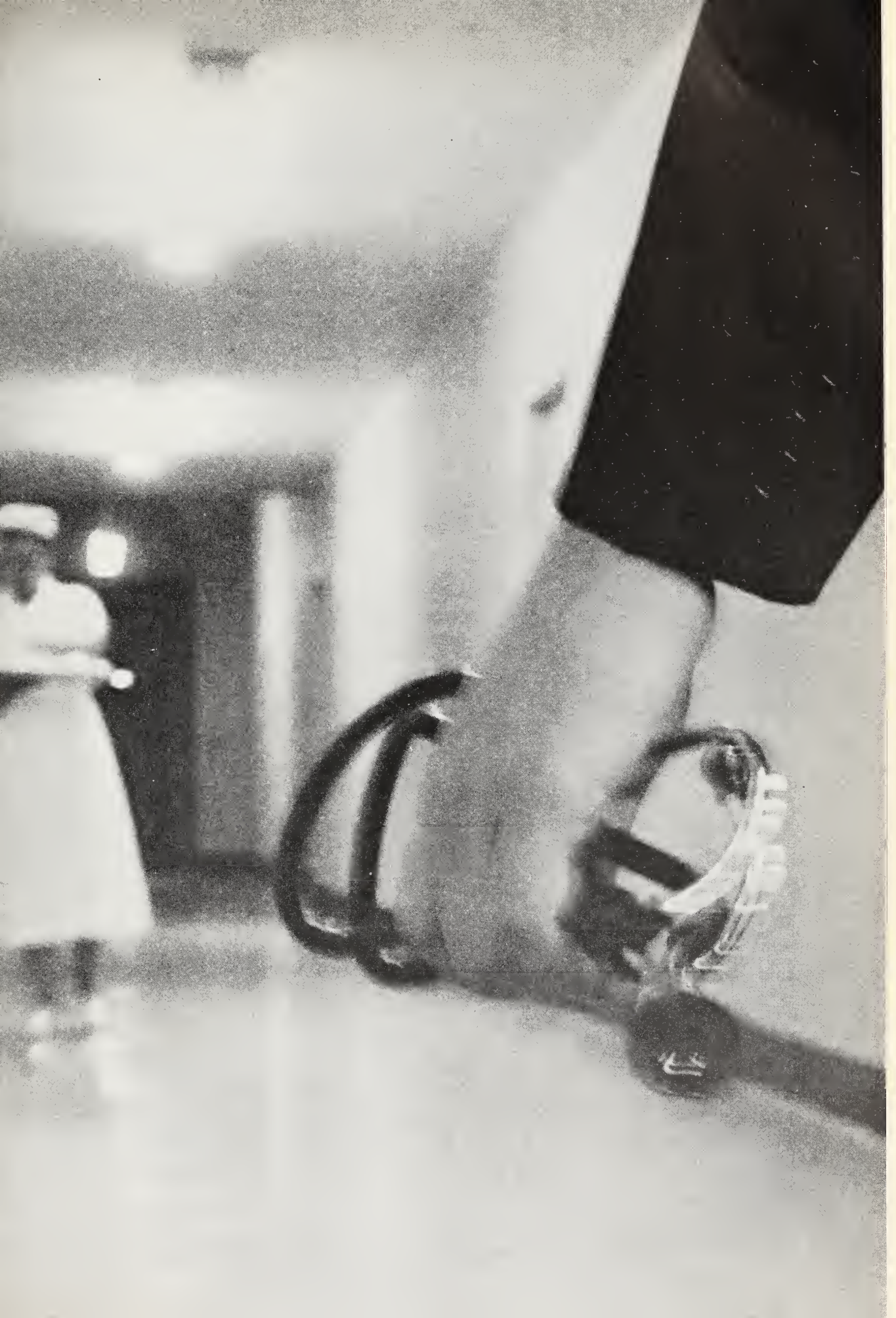
It was decided that no representative would be sent to the Oct. 2, 1961, Council on Occupational Health meeting, to be held in Denver.

On motion of Drs. Glock and Covalt, Dr. Wood was requested to represent the Association at the annual meeting of the Indiana State Chamber of Commerce to be held at French Lick on Oct. 12, 13 and 14.

An invitation to the Association to participate in the AMA Twelfth County Medical Societies Conference on Disaster Medical Care, Nov. 4-5, 1961, in Chicago, was ordered placed on the next meeting agenda for discussion.

The Committee decided no representatives would attend the national meeting of Medical Assistants in Reno, Oct. 13, 14 and 15, 1961.

There being no further business the Committee adjourned to meet at 10:00 a.m., Monday, Oct. 23, at the Columbia Club, Indianapolis. ◀



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Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—The Public Health Service said that radioactive fallout levels resulting in the United States up until early November from the new series of Soviet nuclear explosions "do not warrant undue public concern" nor initiation of any special public health action.

The federal agency said that the prevailing levels were not high enough for the public to be concerned about the safety of milk and other foodstuffs.

But PHS added that "continuous, intensive surveillance" by federal, state and local governments was justified.

In a special statement issued after a two-day conference of government and private radiation experts, the PHS pointed out that "very little is known about the effects on animals or humans of very low but prolonged exposures" from either natural background radiation or fallout from nuclear tests.

"The consensus of scientific opinion is that the most prudent course is to assume there is no level of radiation exposure below which one can be absolutely certain that harmful effects may not occur to at least a few individuals when sufficiently large numbers of people are involved," the PHS said. "This is known as the 'non-threshold' concept."

This concept is the basis for U.S. policies and programs for assessment of radiation hazards and for control measures designed to limit exposures of the population, the PHS said and added:

"When this non-threshold concept is applied to present radiation exposure levels being experienced in the U.S. from all sources, including fallout, the following assessment can be made:

"The extra radiation caused by the Soviet tests will add to the risk of genetic effects in succeeding generations, and possibly to the risk of health damage to some people in the United States. It is not possible to determine how extensive these ill effects will be—nor how many people will be affected. At present radiation levels, and even at somewhat higher levels, the additional risk is slight and very few people will be affected. Nevertheless, if fallout increased substantially or remained high for a long time, it would become far more important as a potential health hazard in this country and throughout the world.

"It is the obligation of our Federal and State governments to undertake all possible measures to assess accurately the public health significance of the present fallout situation, and to prepare for actions to safeguard the public health if these become necessary."

Continued on page 1762

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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.



MONTH IN WASHINGTON

Continued from page 1758

SPRING RAINS WILL WASH IN FALLOUT

Federal officials said radioactive fallout on the United States will increase next February, March, April and May when the late winter and spring rains wash to earth the remainder of the fallout from the Soviet nuclear tests but it isn't expected to reach a danger level. President Kennedy said any U.S. nuclear tests in the atmosphere would be designed to hold radioactive fallout to an absolute minimum.

The PHS said that the nation's health authorities are giving careful consideration to the possible situations that might require various corrective actions.

"It is evident that an important element of health protection is continuous surveillance and analysis," the PHS said.

"To achieve this, a number of Federal-State systems for public health surveillance, detailed investigation, and radiation control measure have been developed . . . In cooperation with State and local health departments, the PHS operates a nationwide early warning atmospheric radiation surveillance network currently comprised of 58 stations, and a 60-station milk radiation monitoring system. In addition, the PHS has well-established networks for general air and water pollution monitoring with a total of 343 stations. All of these include radiation monitoring among their capabilities and all are being expanded. For example, daily samples of drinking water are being collected in 12 major cities and analyzed for specific radioactive content on a weekly basis, and plans are ready for more extensive monitoring if necessary. Rounding out the PHS resources is a system of highly specialized regional radiological health laboratories.

FOOD & DRUG EXPANDS MONITORING PROGRAM

"The Food and Drug Administration has expanded its program of monitoring the levels of radioactive contamination in foods. Working through 18 District offices and 39 Resident Inspection Stations, its inspectors are sampling foods from all parts of the Nation; particularly those areas where the Public Health Service's air monitoring network has indicated the highest concentration of atmospheric contamination. Additionally, FDA collects samples from selected lots of food being imported into the United States.

"These samples are being analyzed for total beta activity and selected samples are further tested to determine what specific radioisotopes are present and in what amount.

"In addition there are the extensive special-purpose radiation surveillance and research facilities of the Atomic Energy Commission and the Departments of Defense, Commerce, and Agriculture.

"All Federal programs and resources work in close concert, and follow the same radiation protection standards, through the coordinating influence of the Federal Radiation Council. . . ."

Supplementing these Federal programs and resources is a steadily increasing radiological health capability among State and large city governments. Their programs are usually centered in the departments of public health, with certain special responsibilities often located in other agencies such as State or city departments of public safety. At every level of government, resources and programs are being expanded to cope with the potentially hazardous situation the nation now faces. ◀



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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.

2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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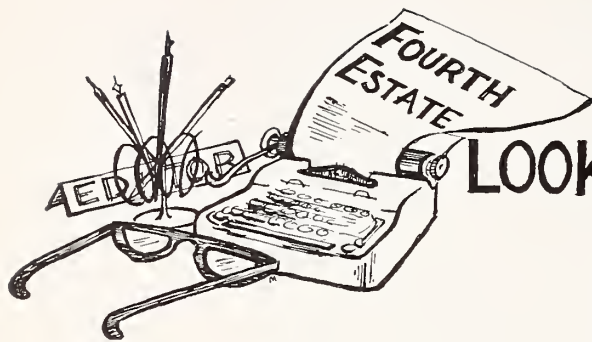
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

War On Quacks

Health quacks have become the object of one of the most intensive manhunts undertaken against one racket since the days of prohibition, with formation of an alliance between the medical profession and assorted government bureaus.

Cure-alls, dietary supplements touted as panaceas for practically every ailment, and electrical gadgets with a strong appeal to the imagination, have long thrived on public gullibility. Medical quackery has reached the point where it extracts an estimated billion dollars annually from the pockets of persons who desperately need competent medical advice, but who instead succumb to a worthless cure because it is quick, easy to take and attractively promoted.

Doctors, individually and through the American Medical Association, have been battling worthless "cures" for many years. The AMA founded a Department of Investigation in 1906 to lead the attack against peddlers of superstitious remedies and worthless concoctions.

In recent years various agencies of the federal government have become particularly active in attempts to stem what appears to be a continually increasing tide of junk medicines, valueless and frequently harmful food fads, and an almost endless list of cleverly designed mechanical and electrical gadgets.

In their own fields, the AMA, the Food and Drug Administration, the Post Office Department, the Federal Trade Commission, the Department of Justice, the National Better Business Bureau, the American Cancer Society, the Arthritis and Rheumatism Foundation, and their many local tributaries, will wage a concerted effort in behalf of the nation's health, as a re-

sult of the first Congress on Medical Quackery recently held in Washington, D. C.

Hammond Times
Oct. 16, 1961

The Auto Fume Problem

According to reports from Detroit, car-makers are including as standard equipment on the new 1962 models such things as heaters and radios and, in some cases, provision for safety belts. But they show little enthusiasm for a \$6 device that would reduce by at least one-third crankcase fumes that help pollute the air of major cities.

Only California requires a crankcase blowby device as standard equipment on new motor vehicles sold in the state. But other states and cities are beginning to wise up to the fume-cutting potentialities of this simple device. Health Secretary Ribicoff has warned he will ask federal legislation to require blowby devices as standard equipment if the auto industry doesn't pledge by January to provide them on all 1964 model cars. The car-makers say they need more time—until next April at least—to finish testing, a schedule which would make it impossible to supply blowby devices on 1963 models.

Blowby is unburned gasoline forced into the car's crankcase by leaky pistons. The fumes escape via the crankcase breather and represent between 10 and 40% of all fumes emitted by the vehicle. The desirability of cutting down on such fumes is self-evident, and the auto industry could make a further contribution to good health by adopting the blowby at the earliest possible time.

Kokomo Tribune
Oct. 5, 1961

Continued on page 1768

SELECTIVE TENSITROPIC LISTICA®

- lifts the facade of TENSION/ANXIETY** New Listica allays tension/anxiety in as many as 89% of cases,²⁻¹³ by selectively inhibiting impulses through internuncial pathways of the central nervous system. Whether the patient's tension/anxiety is psychosomatic or a complication of somatic disorder, Listica reduces or eliminates the excess impulsivity seen in tension/anxiety states.
- maintains normal acuity** Unlike many drugs, Listica does not affect unconditioned response or normal motor activity. Thus, Listica allays tension and anxiety without inducing apathy or impairing acuity; patients are able to pursue normal activities, such as driving, reading, writing, etc., without interference from drug therapy.
- enhances physician-patient rapport** As it removes tension/anxiety, fear and frustration, **LISTICA PROMOTES EUNOIA***—"a normal mental state." It bares the patient's true somatic condition, and facilitates diagnosis and therapy. Patients are more tractable to concomitant drug therapy, respond better, faster.
- without known toxicity or contraindications** Listica is safe, as well as effective. Chronic studies¹⁴ in rats (12 months) and dogs (6 months) were free of toxic manifestations at oral dosage levels as high as 200 mg./kg./day (approximately 10 times the recommended human dosage). No macroscopic or microscopic changes in tissues, organs or blood indicative of toxicity were observed, even at doses up to 320 mg./kg. In humans, there have been no adverse blood, urine or cardiac changes; liver profiles were negative, and jaundice has not been noted.
- without serious side effects or habituation** During three and one-half years of clinical study in 1,759 patients,²⁻¹³ Listica has produced no serious side effects. Less than 4% of patients experienced any side effects, and these were invariably minor and transient. Most frequent (38 cases) was mild drowsiness, which disappeared after the first few days of Listica therapy. Habituation, cumulative effects, or withdrawal symptoms have not been noted, even in patients taking Listica as long as two years.
- with convenient dosage and availability** One Listica tablet, q.i.d., is the recommended dosage. Listica is supplied in bottles of 50 tablets on prescription only, by pharmacies everywhere. Each tablet contains 200 mg. of Hydroxyphenamate, Armour.

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ARMOUR PHARMACEUTICAL COMPANY, KANKAKEE, ILLINOIS

Physicians who prefer generic names prescribe "Hydroxyphenamate, Armour."



FOURTH ESTATE

Continued from page 1764

New Cancer Study

Curing cancer by drugs is a promising field of medical research that from time to time has appeared on the verge of a dramatic breakthrough. About 20 different drugs—none of which is a cure—are in general use against 30 different kinds of cancer. And 160 other preparations are said to be undergoing field tests.

Now, the National Cancer Institute has initiated a major effort to uncover new medicines against this disease. Starting this Friday, it will supervise a program under which 6,000 cancer patients will be treated with a multitude of new drugs during a two-year nationwide experiment.

The idea is to try on all types of cancer every drug which shows promise of being effective. In the past each new anti-cancer drug has been tested only on a particular type of cancer or, at most, a few types. Under the new program, a drug with hidden anti-cancer powers may be uncovered quickly and marketed with minimum delay.

Many medical experts believe it is only a

matter of time before cancer is conquered. Already there are more than one million people alive who have been cured of cancer by surgery and/or radiation treatment. Drug therapy has prolonged many lives. Another possibility under investigation is the immunization of people against cancer, just as today they can be inoculated against polio and smallpox.

No real cancer cure has yet been found. But science is tackling the problem with such intensity that hopes for a cure are high, and we trust they are justified.

Kokomo Tribune
Sept. 12, 1961

'Share the Road'

Proper "sharing of the road" would prevent at least one-half of Indiana's traffic crashes, says the Indiana Traffic Safety Foundation.

During August, traffic safety officials and citizens support groups throughout Indiana will concentrate their efforts on a safety theme entitled "Share the Road." Ample evidence of the need for greater "sharing" is found in Indiana state police records which reveal that nearly 25% of the 100,000 two-car crashes recorded in Indiana in 1960 occurred at intersections. Another 20% of last year's traffic collisions involved rear-end crashes.

The foundation points out that as the number of registered vehicles and licensed drivers continues to mount steadily each year, the necessity for "sharing the road" becomes even more essential to survival.

Sharing the road involves a willingness to make proper use of the streets and highways by constant observance of traffic laws. It also means being continuously alert for those who, through inattention, lack of skill or an improper attitude, commit a hazardous act while driving.

The foundation suggests that driving at reasonable speeds, early signaling of your intention to slow down, stop or change lanes, and a habitual respect for traffic signs and signals are the basic requirements for doing your part to "share the road."

Kokomo Tribune
Aug. 4, 1961

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 54 — December 1961 — Number 12

First Place Winner
Journal Medical Essay Contest

Fear of Death

JOSEPH D. HOWARD, M.D.

Muncie*

IN THE PAST Nature, in most instances, was kind and death came to the fatally diseased with little delay. The interim between the time of diagnosis and death was relatively brief and prognosis was measured in days and hours. The physician's role at the side of the death-bed was limited; limited mostly by the time factor and also by the mental awareness of the patient. The intellectual and psychological concept of dying and death was, for the most part, left to the artist, the clergyman and the philosopher to ponder.

Human intervention in the form of modern medicine with its improved diagnostic technic and ever expanding armamentarium of life-sustaining drugs and surgical procedures has substantially delayed death. Prognosis is now measured in months and even years. We have gone to great lengths to postpone death but simultaneously have inadvertently increased the time of dying. In a sense, we have produced a population of the "living dead." I am referring to the geriatric patient, the patients with "incurable" cancer, leukemia, intractable heart disease, etc. who have to suffer mentally with the thought that they will, in a matter of months or a few

short years, die. For these persons dying and death is not a distantly removed event in time, but has become a fact of imminent psychological and physical reality. Dying and death in these cases becomes the valid concern of the physician and it is his duty in accordance with Hippocratic tradition to support his patient in facing his impending dissolution. That prolongation of life in itself is good is not the question here,¹⁶ but rather, that the prolongation of life has created new problems of management which require a more complete approach in order to make its practice justifiable.

Medicine Meets Challenge Inadequately

To date, medicine has only very inadequately measured up to the challenge. There is a paucity of literature devoted to the subject of the care of the dying, the bulk of which is concerned primarily with the physical needs of the patient and with certain oversimplified general principles of management. The fact that dying a "slow" death is a highly individualized and usually painful psychological process is either entirely neglected or only cursorily mentioned. Worcester,⁵⁴ with great insight into the problem, remarks: "Thus far we have considered only the physical pheno-

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mena of dying. Such knowledge is essential, but right treatment depends still more upon the physician's appreciation of his dying patient's personality. Such appreciation indeed is the foundation of the art of medical practice. It distinguishes the physician from the veterinary. And these suggestions regarding the proper physical treatment are of small importance except as they furnish the doctor sufficient reason for taking care of his dying patients. . . . In the practice of our art it often matters little what medicine is given, but matters much that we give ourselves with our pills."

In extending this same idea, Eissler,¹⁶ states: "One of the greatest barriers to a full grasp of the problem of death seems to me to be the inner compulsion by which we are forced to think of death in terms of impaired physiological functions or of destroyed physical structures. It must be stated that even if biology had said everything that this specialty can say about death, much would still remain to be added by the mental scientist. Death is also a problem of the mind, it may even be principally a problem of the mind and is possibly the foremost problem of the mind; . . . we may well ask what they (the deaths of different persons) really have in common aside from a few biological factors which are the proximate causes of the cessation of the organism. Thus the phenomenon of death must be comprehended first in each instance as an individually formed process. It is formed as individually as each single action had been formed in the pathway which led finally to death. The last moment of life, is, of course, the end product of the total preceding history of the dying person and probably also of that of his ancestors."

If we accept the doctrine that dying and death is a "problem of the mind" and "personality" then the conclusion is inescapable that the psychiatrist has a rightful place in the supportive regimen of the dying. Clinical experience in this area of psychiatry, as reflected in the literature, is again disappointingly wanting. What is lacking in quantity may perhaps be overshadowed by the quality of some of these communications.^{12, 16, 28, 40, 51, 55.} Of these, Eissler's book stands out as a unique and monumental effort.

It appears that the core or central problem creating mental anguish in the dying patient, to which the psychiatrist or physician must attune

himself, is fear; fear of death. Bean⁵ comments: ". . . the great terror of death is fear, and fear can be defeated. Not only small skirmishes but whole campaigns can be won in this cold war. If, as he must need do, the physician accepts ultimate death as inevitable, if he relieves it of terror and pain, he has done all that should be expected and all he can do." This fear which is at the height of its intensity in the face of impending death goes to make the act of dying a unique and delicately balanced clinical event demanding a distinctive psychotherapeutic approach. An understanding of this phenomenon (fear of death) is prerequisite to constructing a rational thanatopsychotherapy. It is the purpose of this paper to explore some of the theories and concepts relating to this phenomenon and to discuss one of the more prominent ego defenses that may be employed to reduce this fear to a tolerable level.

Clinical Importance

Several preliminary remarks are in order. The opinions expressed in the literature are divided as to whether the fear of death is clinically important. Some authors feel that most persons face death with equanimity. Others, by far the majority, believe that the fear of death is significantly ever-present but manifested to a different degree in each dying patient. Our research and statistics, however, on this matter are too inadequate to definitively affirm either assertion.

There appears also to be some disagreement regarding the exact event which is anticipated by the dying patient and which is responsible for inducing his fears. A minority of authors⁴ believe that patients react primarily to a discomforting imagery of the events leading to death, i.e., the dying process, the character of which is always so uncertain. However, most writers^{16, 48} agree it is the end result—death *per se*—that they dread. It is my feeling that the fear of dying, which is probably the same as the fear of annihilation, contributes only slightly to the overall fears of the dying, and that it is the fear of death (fear of cessation of being) which is the most significant component. One can intuitively appreciate this difference by conceptualizing dying as a finite transient state and death as an event eternally final.

Assuming that the dread of death is the important factor, one might conclude that one can avoid this unpleasantness by simply withholding

from the patient the disastrous implications and nature of his affliction. Such is not the case, however. We must first recognize that "awareness" or knowledge of personal imminent death can be viewed as being on an unconscious or a conscious level and further, that this "awareness" may possibly be innately (internally) or externally derived. Eissler¹⁶ believes that man always has an inherent unconscious knowledge of his impending death, at least when it is brought on by internal reasons, i.e., by disease as vs. a violent death. He states, "Although it cannot be proved empirically that such unconscious knowledge is present in each instance, it is necessary to assume its presence in case mental lucidity has been preserved. I have noticed in some instances that when a patient's condition takes a turn for the worse, he stops asking the physician about the prospect of his recovery."

Another author¹² believes presentiments of death to be externally derived and more or less consciously comprehended and that it represents a phenomenon, mostly nonverbal, of communication. He remarks: "... forebodings are forged out of the whisperings at the bedside—often unduly loud and obnoxious—out of the perusal of the case notes, the conscious contemplation of the body, the obvious experience of chronicity and lack of relief, the preconscious perception of body dysfunction occurring in dreams (when the mind is turned in to the body) and to the summatory lysis of intuitive dreams."

This is not to presume that we should verbally confirm these premonitions in all cases. The idea of an inevitable early death, to some individuals, may be so overwhelming that it might potentially trigger a withdrawal into the depths of a psychoneurosis, or more drastically, into the oblivion of a psychosis. Daniel Cappon concludes that such deliberate verbal verification may actually hasten the act of dying. When we do not provide from without a husk into which the patient can fit his forebodings we can manage to foster, by omission, a reasonable degree of "hope" in the patient. In this negative maneuver we aid the ego in utilizing its weakened defenses of repression, denial, rationization, etc. . . . for subduing the fear of death and maintaining the ego at a higher level of integrity. The matter of "truth-telling" in the final analysis can only be answered in lieu of an appraisal of the patient's individual personality and his preparedness to meet death.

There are others who believe that forebodings of death are unreliable and only infrequently experienced.^{19, 22}

Fear Involves Knowledge

The fear of death is an extremely complex phenomenon. It may perhaps transcend human understanding for it involves knowing something of the true nature of death and life itself. It would be too presumptuous and egotistical to suppose that we can ever fully comprehend these states of being and not being. In spite of this obstacle, the psychology of the fear of death has attracted the interest and imagination of the mental scientists who have, at least sporadically, attempted to offer a logical explanation of this intricate and mysterious fear.

To my understanding, the fear of death is a dichotomous conception. Interpretation of the when and why of its occurrence varies according to the set of circumstances in which it becomes manifest. In one instance there is that concept of the fear of death which develops to the degree of a phobia or an obsession. Mary Chadwick,¹⁵ commenting on this particular moiety, states "... it is found in persons for whom there is no immediate or known menace to life, when physical health is excellent, and assurance of medical opinion by no means mitigate the anxiety except for the shortest period." In such a context the fear of death represents a neurotic reaction to basically internal unconscious conflicts. Death as the cessation of being is not feared but some "irrational unrealistic" symbol of death. Such a response should preferably be designated as death anxiety or more elegantly, thanatophobia.

Freud was perhaps the first mental scientist to explore the psychodynamics of the death anxiety. He regarded it purely as a secondary substitutive phenomenon of the castration fear which grew out of an inadequately resolved Oedipal conflict. This remained as the accepted explanation for many years. There was no attempt to study the phenomenon further, the clinicians being perfectly satisfied with this conception. More recently, however, there has been a renewed impetus in the investigation of this problem because the theory advanced by Freud did not account for all of the known facts.

Wahl³¹ in criticising Freud's theory, remarks: "Present day experience does not altogether support these views. Thanatophobia is a frequently

encountered fear in children. One may see it in evidence as early as the third year. Its appearance seems to be contiguous with the development of concept formation and the formation of guilt, both of which greatly antedate the Oedipus complex."

In its place Wahl⁵¹ proposes that anxiety about death has its genesis in the formative years of ego development when the child is suffused with infantile omnipotence. According to him, this anxiety arises as a consequence of two factors, i.e., guilt and fear of reprisal. The guilt is sustained through the fantasy murders perpetrated wishfully (banishment=death wishes) in the imagination of the child against his frustrating agents (usually the parents or some similarly ambivalently loved significant persons) during his (the child's) socialization. The fear of reprisal or fear of personal death comes about via operation of the law of Talion (to think a thing is to do that thing, to do a thing is to insure equal and similar punishment on to self), again because of these fantasy murders. Zillboorg,⁵⁵ Chadwick,¹⁵ and Rosenthal⁴⁰ tend to support this more basic view.

Some remarks of Eissler's¹⁶ are germane to our discussion at this time. He states: "However, the concept of fear of death ought to be kept apart from that fear of annihilation. The latter is ubiquitous: in order to experience it, no particular differentiation within the ego is required. It is not always easy to distinguish these two fears, one of which easily slides into the other. I would tentatively say that the fear of annihilation pertains primarily to the fear of the body's destruction but does not necessarily include the destruction of the psyche, soul, ego, or personality, or whatever still must be added in order to convert fear of annihilation into fear of death. The early fears of the infant and of the child probably are fears of annihilation, the fear lest something dreadful will occur. The destructive nature of the impending event will be strongly represented, but the exact nature of the event aside from its extremely displeasurable quality will be left vague." In effect, Eissler's remarks may be construed as a counter criticism against Wahl's notion of the death anxiety manifesting itself in the pre-Oedipal period.

Wahl's formulation⁵¹ is creditable and at times profound. However, it was difficult to discern in some instances whether he was discussing thanatophobia, fear of death as cessation of being, or

fear of annihilation. These three entities were ambiguously used in many communications dealing with this subject. I point this out only to demonstrate the complexity of the fear of death concept and some of its attendant pitfalls. To singly discuss each theory accounting for the death anxiety is beyond the scope of this paper. In passing, it may be mentioned that most writers concur death is feared symbolically commensurate with the degree of distortion and perversion of personal concepts of death. It is also agreed that no one escapes a certain amount of symbolisation in his abstraction of death and that this is no less socio-ethnologically than individually determined.^{6, 13, 29, 31}

The second basic notion to which the term fear of death should be restricted, constitutes the other aspect of the dichotomy. It is most poignantly exemplified in situations where there is an actual threat and danger to life as in the case of the fatally diseased patient. In this instance, the fear of death is interpreted as the affective component of a reaction to an objectively approaching event which is anticipated by the protagonist as the cessation of being. One has the feeling that it is improper to speak of his fear as "irrational" and "unrealistic," but rather to regard it as a "natural" and "normal" response. Under these circumstances the fear of death appears as a simple, irreducible, self-evident reaction devoid of a psychology and outside the realm of psychiatric help. But before making such a premature conclusion, let us first explore the nature of this particular concept of the fear of death.

The Unconscious Level

The fear of death as a psychobiological end is universally shared by mankind and includes those persons relatively remote from internal or external life-threatening forces.⁵⁵ This is man's lot because of the peculiar state of his knowledge of death. He cannot imagine his personal destruction because there is no representation of death in his unconscious.⁵⁹ He can never acquire a conception of true death simply because he has never experienced it.³⁰ Unconsciously he does not or cannot acknowledge the reality of death.^{51, 55} On the other hand, man is the only species which knows of death to the extent that it is certain, inevitable, and irreversible.^{16, 61} Intellectually (consciously) he can appreciate the fact that his freedom from forces of disorganization and disintegration is only transient, i.e.,

that life is finite. However, man could not function adequately if he were incessantly consciously plagued by his inescapable doom. Therefore, in the healthy person's psyche the conscious knowledge of personal death is usually heavily and expensively repressed and denied. It is only when man is confronted with an immediate prospect of his own destruction that these ego defenses deteriorate. In such circumstances the fear of death is awakened and breaks through to the surface whence it becomes a source of mental pain and suffering.

One wonders why death is wholly unacceptable at the unconscious level. At best, only speculative answers can be given.

It is a major premise of this paper, consistent with the thesis that "behind every fear there is a wish," that man has a basic desire to be and feel omnipotent. This sense of omnipotence in its purest form is characteristic of our early infantile existence when the narcissistic self is identified with the cosmos and the ego is said to be in the "oceanic state." Teleologically speaking, vestiges of this infantile omnipotence persist throughout life in order that we may function adequately in our hostile destructive world.^{30, 51, 55} Man, the master of the physical world, is, however, utterly impotent in manipulating and controlling death. Death, the greatest challenger and ultimate victor over man, is a foreign and incongruous event whose reality must remain inadmissible to our omnipotent unconscious psyche.

Suicide Masters Fear

However, man uniquely has at his disposal a magical psychopathological means of escaping death. He attains this by being instrumental in his own demise, i.e., an active death by suicide. Wahl⁵⁰ states: "A third motive, and one more recondite, is the employment of suicide as an aid in coping with an overpowering thanatophobia or fear of death. Suicide in this sense serves as a reaction formation to the morbidly feared eventuality of death by embracing it rather than running from it." As a correlate we may state that man fears a passive death, a death in which he has no hand, a death which is determined by forces beyond his control. In the act of suicide we can by our individual will determine the time, place, and manner of our death thereby indirectly mastering death.

Paradoxically, the dying patient who is in extreme dread of death may actually wish for and

strive for death. Cappon¹² remarks: "What one might call the motivational status in dying, bends toward death. . . . Despite extensive maneuvers, even blatant denials, the majority of the patients studied wanted, passively or actively, to die or at least not to live. . . . Clearly the popular belief that even dying people want to live is based on the wish of those living vigorously that the dying should do so. . . . Thus one might surmise that when facing inevitable death, albeit consciously denied, mental energy ebbs, the goal changing equally inevitably. Negative or even destructive trends are revealed more than ever." Zillboorg⁵⁵ also points out that aggressive sado-masochistic drives are intimately connected with fear of death.

The wish for death may possibly be carried out by the dying patient in more subtle ways than we are accustomed to thinking of suicide. Psychosomatic medicine has become an accepted and respected branch of the healing arts. The mind, however, may have a greater influence over the body than even this science implies. Psychic suicide may indeed be a possibility.^{9, 11, 37, 52} Other writers have suggested that all illness and disease may in fact be a unitary reaction to psychic stress and that all cases of death may be ultimately psychogenic.^{12, 16}

The question of the existence of a death instinct invariably arises in relation to such a discussion. It would be too far afield to go into the pros and cons of the death instinct theory at this time. Suffice it to say that only a few mental scientists^{16, 33, 53} hold to a dualistic (life "Eros"—death "thanatos") theory of instincts. The majority^{8, 20, 30, 46, 49, etc.} instead believe in a unitarian instinct theory—a life instinct. Their (the latter) explanation of man's aggressive destructive behavior is that they develop in response to environmental interference and perversion of the life instinct. Whether instinctual or not, hostile, destructive, aggressive and negative drives—both externally and internally directed—do exist. The therapist, in his relationship with the dying, should be especially aware of his patient's possible death wishes and the potential activation of self-destructive forces.

Wish for Immortality

A second major premise of this paper is that the ego's aspirations for omnipotence extends into the dimension of time and results in a basic wish for control over the future, viz., a wish for immortality.¹³ Man's sense of, striving for, and

achievement of immortality represents a primary mechanism of defense against death and death fears.

When man fears death as the cessation of being he does not fear it as the extinction of physical being except to the slightest extent. As mentioned earlier, he may experience some dread of the physical pain and suffering attendant to dying, but he can take solace in the fact that this is only a temporary state. We do not mind surrendering our body to death, for we lose only a small fraction of our individuality. Man can, I believe, integrate into his thoughts the notion of his own somatic metamorphosis of organic to inorganic without too much discomfort. What we mostly fear is extinction of our individuality as a person.^{10, 15, 16, 32} The seat of our individuality is our personality, soul, ego, or psyche which is a unique supernumerative product of having lived in a particular space-time co-ordinate of a four dimensional universe—a duplicate of which has never or will ever come to be. The disturbing question, to which no one can ever give a definite answer because he has never experienced death, becomes one of whether our individuality persists eternally or ceases abruptly with death. Death can be viewed as an unresolved conflict of Fear (fear of cessation of our individuality) vs. Faith (faith in our immortality).

It has been postulated that no one is free, at least in some form, of a belief in his own immortality.^{30, 50, 55} There are many varied concepts of immortality, perhaps as many as there are separate individuals. They are not mutually exclusive but in fact probably exist in the majority of persons as admixtures. These concepts and the manner in which we believe we have fulfilled them determine to a large extent our acceptance of and attitudes toward death.

Our immortality may be a religious belief in an after-life, or posthumous influence via our contributions to art and science, or our stake in immortality may be achieved simply through procreation and our progeny, etc. We will be ready, perhaps not happy, to die if we are certain that some portion of our individuality is preserved for eternity and that it will continue to influence, control, and determine in some way the future pattern of man and the universe. Plato, Freud, Einstein, Hitler, Bach and Christ who long after their deaths still have a tremendous hold on present-day man's ideas, beliefs and actions, have

achieved a form of immortality. We can then, in a sense, escape death by the quality and quantity of our immortalizing acts while in the mortal state.

In conclusion, the role of the therapist in the case of a dying patient is twofold. He should dispel by conventional psychotherapeutic technique any irrational unrealistic symbolic fears harbored by the patient concerning death. Secondly, because there are no appropriate defenses or emotions to sustain the experience of approaching death the therapist must make a search for support, and reconcile the patient to his personal concept of immortality.

Summary

This paper discusses the triad of the doctor, the dying patient, and death. Dying is represented as a highly individualised, often psychologically painful, emotional experience in which the physician's role is that of helping the dying patient face his impending dissolution. Management centers primarily on the dying patient's fear of death and secondarily on his fears of the dying process. The association and importance of the fear of death and aggressive sado-masochistic drives is pointed out.

The fear of death arises from the individual's personal conception of death. These concepts, notions and ideas concerning death are determined by the dying patient's past-life history and certain death-oriented socio-ethnological attitudes. In addition, concepts of death and the resultant death fears have irrational neurotic symbolic elements which are interwoven with the realistic objective fact of the inevitability of an imminent psychobiological end. The former can be managed with the standard psychotherapeutic methods of present day psychiatry. The latter requires a specific and unique thanatopsychotherapy.

An ego reinforcing, quasi religio-philosophical, approach is suggested. It is based on the assumption that the fear of death and beliefs of immortality are universal phenomena of mankind and that by reconciling the patient to his mental construct of immortality the therapist may considerably reduce the psychic pain attendant to the dying process.

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Gallbladder Anomalies

With a Report of a Double Gallbladder

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DUPLICATION ANOMALIES of the gallbladder are quite rare,^{2,14} and satisfactory roentgenographic demonstrations of these anomalies, even more uncommon.¹⁹

Recent demonstration in a patient of two separate gallbladders, each drained by its own cystic duct, and the paucity of studies in radiologic literature has prompted this report.

Classification

Boyden,³ in his exhaustive study in 1926, classified gallbladder anomalies into the following three groups:

1. *Vesica fellea divisa*-bilobed gallbladder. In this condition there is incomplete duplication of the gallbladder and a single cystic duct drains both cavities. There are two types of anomaly found:

A. *Septal type*: The gallbladder may appear normal externally, but on opening will show a longitudinal septum partially dividing the organ into two chambers.

B. *V-shaped type*: There is complete division of the fundic and corporeal portions of the gallbladder into equal or unequal lobes, with fusion at the neck and drainage by a single cystic duct.¹²

2. *Vesica fellea duplex*-double gallbladder with two cystic ducts. There are two separate and distinct gallbladders and each must be drained by its own cystic duct.

A. *Y-shaped type*: There are two cystic ducts uniting before they enter the choledochus. The two gallbladders are usually adherent and occupy the same fossa.

B. *Ductular type*: The two cystic ducts empty separately into the common bile duct. The two gallbladders are usually separated, and may occupy different lobes. This is the most common type in man.¹⁸

3. *Vesica fellea multiplex*: Until recently only demonstrated in animals. Skielboe¹⁸ in 1958, then Kelly¹³ and Hause¹⁰ in 1959, reported separate cases, each with three gallbladders.

The hepatic diverticulum originates on the ventral surface of the entodermal lining of the foregut at about the fourth week of fetal development. Gallbladder anlage begins as a bud arising at the base of a maze of cell cords arising from the diverticulum.

Cells of the gallbladder bud proliferate, giving rise to a number of cavities separated by septae. These cavities normally fuse into one large cavity, but when they fail to unite, supernumerary gallbladders are formed.^{1,19}

Review of Literature

Double gallbladder is uncommon in man, being seen in approximately one of 4,000 cases. It is common in domestic animals with the incidence being one in eight for cats, one in 28 for calves, one in 85 for sheep and one in 298 for swine.³

Gross,⁹ in 1936, in a comprehensive study of congenital duplications of the gallbladder, found

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34 human cases in the literature and added one of his own. In 1956, Flannery and Caster⁵ concluded that the total number of reported cases of double gallbladder was 64. Eight of these were of the bilobed, or divided type with a single cystic duct.

Skjelboe,¹⁸ in 1958, in reviewing all the literature available, found 101 reports of double gallbladder. Sixty-six cases were proven at operation or autopsy. In eight of these the diagnosis was made before operation by x-ray examination. Thirty-three were of the ductular type, 11 were of the Y-shaped type, one was a variation of either the ductular or Y-shaped type. The bilobed type was encountered in 15 instances and the remaining six cases remained unclassified. Thirty five cases were proved by x-ray only. Other recent reports in the English literature^{1,6,7,8,12,15} have added six cases to this number.

Moore and Hurley,¹⁴ in summarizing symptomatic cases, found that in the majority of cases the symptoms were those of cholecystitis and cholelithiasis. Seventy-five percent of the patients were women with an average age of 43. They indicate that although occasionally only a pathological gallbladder was removed, leaving a normal one, the surgical management in the majority of symptomatic duplications has required removal of both gallbladders, either because of their intimate approximation or because both organs were diseased. Carcinoma has been found associated with this type of anomaly.¹⁷

Case Report:

A 36-year-old female was admitted to the Clark County Memorial Hospital Sept. 3, 1960, with the diagnosis of acute alcoholic and salicylate gastritis. From the clinical viewpoint no other special points of interest were elicited. A cholecystogram was performed as a part of a complete gastrointestinal tract study.

Examination of the gallbladder on Sept. 6, 1960, after oral administration of 3 gms of telepaque (Figure 1, 2 and 3) showed two separate gallbladders with considerable overlapping of the fundi. No calculi were observed.

Further study on Sept. 7, 1960, (Figure 4 and 5) 30 minutes after the oral ingestion of a fatty meal, showed normal contraction and emptying of the organs with visualization of a cystic duct draining each organ. The anomaly was considered asymptomatic in this patient.



FIGURE 1
POSTERIOR-ANTERIOR film of the gallbladder area showing a double gallbladder.



FIGURE 2
LEFT ANTERIOR oblique projection shows two separate fundi of the gallbladder with considerable overlapping. The ductal system is not seen.

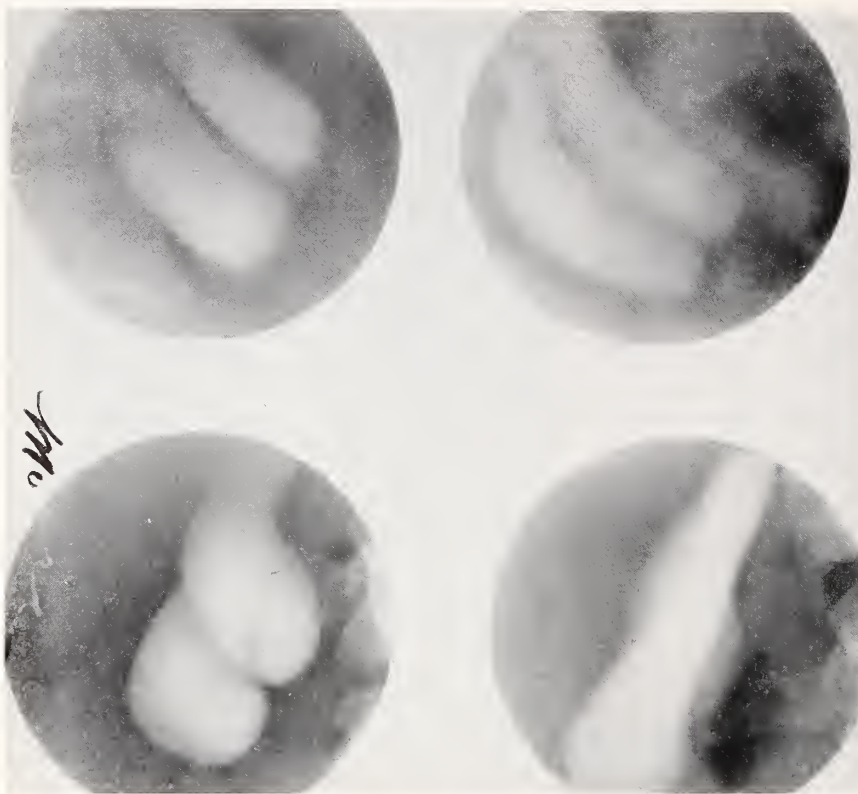


FIGURE 3
UPRIGHT SPOT FILMS of the gallbladder demonstrating the organs in multiple projections. No calculi are observed.



FIGURE 4

FILM IN the posterior-anterior projection thirty minutes after ingestion of a fatty meal shows excellent response to the stimulus. The ductal system is filled.

Roentgen Diagnosis

Cholecystography is the most important means of detection of gallbladder disease and this is true of the detection of anomalies.¹ In patients where both organs function well the diagnosis presents no particular challenge; however, in other instances, diagnosis may be difficult.¹⁵ When the structures are contiguous they may have a common peritoneal covering and appear on the roentgenogram as a single structure.

Occasionally, on roentgenograms two distinct rows of stones may be demonstrated, leading to a correct diagnosis.¹¹

Climan⁴ is credited with reporting the first known instance of a double gallbladder demonstrated by cholecystography. Nichols¹⁶ reported an early case where the diagnosis was made by visualizing separate rows of calculi in the organs. Verstandig and Moore,¹⁹ in 1948, stated that the roentgen incidence of double gallbladder was comparatively rare and were able to find only nine reported cases in the American literature and two in the British literature. They added a case of their own diagnosed by cholecystography.

The diagnosis may be missed if one gallbladder contains stones, or is sufficiently inflamed

to prevent function, while the other remains normal and produces a normal radiographic appearance.

Munson and Teixido¹⁵ report one patient with a double gallbladder which required two operations at an interval of five years. On the first cholecystogram only a single gallbladder with calculus formulation was observed. The second gallbladder was not visualized. Later study showed other calculi, which at subsequent surgery were found in the second organ.

Summary:

1. Duplication anomalies of the gallbladder are rare and satisfactory x-ray demonstrations of these anomalies are particularly uncommon.

2. The literature is reviewed and a case is presented demonstrating roentgenologically a double gallbladder with each organ being drained by its own cystic duct; an example of the ductular type.

3. Surgical removal of both organs in symptomatic patients remains the treatment of choice.

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FIGURE 5

OBLIQUE VIEW SHOWING the separation of the two gallbladders each drained by its own cystic duct. One cystic duct joins the common bile duct almost immediately, while the second turns inferiorly paralleling the common bile duct closely throughout most of its length.

Antipoliomyelitis Vaccination: An Evaluation of the Present Status

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FORMALINIZED POLIOMYELITIS VACCINE,¹ which I shall subsequently refer to as "killed vaccine," has been available to the medical profession in adequate amounts since 1957. Since that time, experience has been accumulating upon the safety and effectiveness of the killed vaccine in the United States and several other countries. During this time, manufacture and testing have been stabilized to improve the quality of the vaccine and numerous experiments designed to answer various questions concerning the effects of such vaccine in man and animals have been done.

Concurrent with these events, there has been a large number of experiments on a vaccine composed of three individual types of "attenuated" live poliovirus vaccine which have been administered in various parts of the world, mostly in the Soviet Union and in Latin American countries.²

Since the rapidity of developments in each of these endeavors has been great and the proponents³ of the different approaches to the problem of poliomyelitis prevention have been strong in their claims for their point of view, the present status is that of a controversial and somewhat confused state in the minds of those who must shoulder the burden of supplying vaccine, those who must administer it and those who are to take it themselves or procure it for their children.

Thus we are now at the point where we have

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considerable experience with a killed vaccine and know its limitations and its benefits after five to six years of actual use. We also have a partly emerged live virus vaccine, experience with which is much more limited in the United States, and which is, of necessity, clinically tested in areas where killed virus immunization and/or natural immunity exists. Therefore, comparable information on absolute safety and effectiveness is not available to anyone.

With this as a background, the physician is now urged to abandon one method and adopt another one.⁴ The purpose of this paper is to present information available which serves to guide me, as a physician, when I have to decide what my further recommendations should be in regard to poliomyelitis vaccine. I will briefly outline those pieces of information which guide me in making a decision for which I can assume moral and medical responsibility.

Let us first examine the information concerning the history and principle of the killed polio vaccine and then, briefly, present production and testing information. Finally, let us take a look at the record of safety and efficiency in regard to the killed vaccine. Following this, I will attempt to compare the two methods.

Killed Polio Vaccine

Killed polio vaccine as devised by Salk¹ is a relative of many other significant immunizing agents, detoxified or killed, as the case may be, by formalin treatment. The great contribution of formalinized toxoids by Ramon^{5,6} has made

possible, since 1925, the control of diphtheria and tetanus. We must note that the final and great reduction in the incidence of these diseases came almost fifteen years later, when sufficient application of these agents was made to achieve major control.

Influenza vaccine and other viral and bacterial agents had been treated with formalin before Salk used the method on tissue culture virus to make polio vaccine. Salk applied the procedure in a more scientific, precise method than had been done previously for any immunizing agent; thus was achieved an inactivation of the antigen which leaves it essentially as potent an antigen as is the same amount of live virus vaccine, if such live vaccine is injected under experimental circumstances in which no multiplication occurs. This means that the formalin does not significantly damage the antigen and thus immunization with it is strictly comparable to nonmultiplying live virus.⁷

This vaccine has an effect of immunologic sensitization in the same manner as does the well known tetanus and diphtheria toxoids, by which it is possible to produce long lasting immune and hyperimmune states by multiple injections.⁸ So much for the principle.

Production, Testing Procedures

The information on production and testing is extremely important in this consideration. As we know, there was an unfortunate accident in the early development period of this vaccine, stemming from insufficient knowledge of and experience with production and testing methods.⁹ The production procedure, it is not generally known, still consists of two different tissue culture methods used by various companies. The Maitland¹⁰ procedure, modified by Enders et al.,¹¹ used for making vaccine by Salk's method for the field trial in 1954,¹² is used by at least two companies today. Our experience is based entirely upon the Maitland method. The remainder of the manufacturers apparently use the so-called trypsin cell method, which was never subjected to a large, controlled study, so that the effectiveness of Maitland vaccine is known more completely than is that of the trypsin vaccine.

The filterability of the Maitland culture grown virus is greater than that grown by the trypsin method, and the trypsin virus, in the early days, failed to inactivate properly and thus live virus

accidentally got into some lots of one manufacturer's product.⁹ Following this, regulations for production were set up wherein all manufacturers must filter the vaccine twice, whether necessary or not.¹³ This reduced the potency of the vaccine an unknown amount,¹⁴ since the monkey potency test is not able to measure relatively small quantitative differences, and, also, since there was a significant change in the potency procedure at about this time.

During the early days, safety was uppermost in the mind of everyone and some potency was sacrificed in order to achieve safety. The requirements had to be set at what is now realized, in retrospect, as a fairly low level in order that commercial production procedures could meet the requirements, and thus some considerable quantities of acceptable vaccine would be available, inasmuch as at that time poliomyelitis cases averaged 25,000 to 35,000 per year and the need was urgent.

The average potency of all polio vaccine manufactured in the United States is now much higher.¹⁵ Production difficulties, generally, have been eliminated and the potency requirements now have been raised.¹³ These facts are significant now because the less than 100% effectiveness seen in the accumulated record must not be assumed to be the best achievement possible with this method.

In the interest of safety and effectiveness, changes must be made only after long periods of testing the products of the change. Therefore, changes come about slowly and with due care and deliberation. Thus the answer to the criticism often voiced—why hasn't the present evolution moved faster?

Reversion to single filtration in the Maitland type procedure probably would increase potency. This step is now possible, since there has developed, step by step, an extremely rigid and dependable safety test which must now be applied to all killed polio vaccine.¹³ This test will be compared later with that which is applied currently to live virus vaccines.

The use of alum adjuvants,¹⁶ different dosage schedules and increased dosage¹⁷ will, no doubt, move the effectiveness progressively nearer to 100%. Concentration attempts thus far made have not, in my opinion, resulted in vaccines significantly more potent, except under experimental conditions when more than an economically feasible amount of antigen was used.¹⁸

Other methods to accomplish this are almost certain to develop.

Degree of Effectiveness

What has been the general experience of effectiveness? The United States Public Health Service has maintained a year-round vigil on this subject and has studied, each year, the degree of effectiveness which could be derived from noting the correlation between vaccination status and number of injections and the development of paralytic poliomyelitis. The effectiveness has been quoted as high as 90% and as low as 80% for those patients who have received four injections of the vaccine.¹⁹ There was, in 1959, an epidemic in Massachusetts,²⁰ consisting mostly of type III cases, in which the vaccine failed to protect to the same extent. This was associated with two lots of vaccine, upon which, as yet, there has been insufficient study to determine any possible reason for the lack of effectiveness.

The general picture on the efficiency of the various types of poliomyelitis vaccine present in the killed vaccine is of interest in relation to the prevalence of these types now in the population and to the experience in Massachusetts where there apparently was failure to immunize a considerable number of the vaccinees. The immunizing potency of the various types of monovalent killed vaccines, as measured by laboratory tests, is consistently in the order of type II greatest, type I intermediate and type III least. The suppressive effect of the vaccination in the population seems to correspond to this order, and some adjustments in the quantity of antigen in at least some vaccines have been made to attempt to fill the need for more of types III and I and less type II poliovirus antigen.

There also is considerable epidemiologic evidence: In countries where vaccination has been almost complete with killed vaccine, the polio rate is practically nil.

In the United States this year, polio is approximately five percent of that which was present, on the average, in the days before vaccine.²¹ There should be caution in ascribing the decline of a disease to a single procedure, but there is a very significant amount of evidence that vaccination has had a decisive effect. These evidences are, first, experimental and second, epidemiological observation.

In general, killed vaccine is believed to protect the individual by providing him with anti-

bodies which would arrest the transport of virus from the gastrointestinal tract to the central nervous system at the time the virus gained entrance into the blood. Rather early in the development of killed polio vaccine, one of the pioneers in polio research, Howe,²² showed that antibody in chimpanzees, produced either by infection or vaccine injection, could be correlated with virus excretion after oral live virus administration. Clinical evidence also has accumulated to indicate that a "herd immunity" effect has been noted where a significant number, but not all, of the population were vaccinated.^{23, 24} This indicates that the killed vaccine also does affect the degree to which virus grows in the gastrointestinal tract of a patient and, therefore, the degree to which the virus spreads in a community. Recently, Bodian and Nathanson²⁵ have shown by precise chimpanzee studies that virus excretion from pharynx and intestines is strongly influenced by antibody injected as "passive" antibody in the form of human gamma globulin. This effect also has been noted in children vaccinated with killed vaccine.²⁶ Thus it now appears that killed polio vaccine has a significant effect on the herd immunity as well as upon those vaccinated. Heretofore, it had been thought that only live oral virus feeding could accomplish this effect.²

Comparison with Live Vaccine

How does the above information compare with information concerning live poliovirus vaccine? Here, we must also examine the principles and testing and the experience thus far. I am dependent upon the literature and information gained from others, since I have had no experience with live polio vaccine.

The principle of the live vaccine is that strains of a poliovirus have been either found or selectively developed that have less than the virulence of strains in nature. Appropriate preparations of such agents, preserved in live form, are administered by mouth to patients, which usually causes no visible damage. Following this infection, there appears resistance to future infections with this virus in the gastrointestinal tract and also some antibody development. The patient excretes virus for a considerable period and this virus spreads in the community, to some degree, mostly within families.²⁷ The difficulties generally mentioned are the failure of "takes" in case the vaccinee has other viruses in the gas-

trointestinal tract at the time of vaccination and the fact that the ingested poliovirus becomes progressively more virulent on passage from one patient to another.^{28, 29} There are other general problems concerning live agents which apply here also, but these will be mentioned later.

The risk of paralytic disease from such live vaccines is difficult to assess except in retrospect, and the determination of whether the vaccination or a "wild strain" is the cause of poliomyelitis occurring following vaccination is a problem of difficult medico-legal nature. It is required that each type of poliovirus be given separately and it is currently recommended that a fourth dose be given which is a mixture of all three types. There is no practical way by which it is determined that a "take" has occurred. Information upon the duration of immunity is not yet established to the same extent as is the case with the killed vaccine, where duration has now been studied for nearly 10 years and found to be quite satisfactory.

The degree of effectiveness has not been tabulated in a manner comparable to the killed vaccine because there has not been sufficient time, and when there has been use of live vaccine there has always been a significant percent of those who were treated with it or were exposed to it secondarily who had previously had some, or all, of the killed virus injections, so that much of the evaluation on safety and effectiveness is not very clear, although proponents of the method claim highly satisfactory results.³ In my opinion, further experience is needed to determine the actual safety and effectiveness of this method.

No Controlled Testing

Finally, because of the above circumstances, it must be realized that there has been no controlled test such as was done in the 1954 field trial with Salk vaccine.³⁰ It also should be pointed out that the tests for safety are vastly different in the case of the different vaccines. With killed vaccines, the tests are designed for the determination of the presence or absence of live virus, and there is no concern about passing inactive virus to others and its exaltation in virulence on passage. In live vaccine, the safety test consists of personal evaluation of the degree of "neurovirulence" in monkeys, not the presence or absence of live virus, but to what degree does the virus infect monkeys on intraspinal injection. While there are complicating factors in

both procedures, generally it is easier to devise tests which are consistent and dependable which are designed to make certain that harmful agents are not present in a vaccine. In the case of living agents, one must depend upon estimates of the degree of animal virulence, and there are many factors in host resistance and virus behaviour that make such tests subject to variations which are potential hazards.

Both killed and live polio vaccines may be, and have been, contaminated with unknown agents from monkeys.³¹ This is a problem recently encountered when both experimental live poliovirus vaccine and some production lots of killed poliovirus vaccine contained a monkey virus, known as Simian Virus 40. For reason not yet fully explained, vaccines produced by the Maitland method have been almost free of this problem. This virus is difficult to kill and must be excluded by special tests recently devised. Its presence has done no known harm, but it is proper that all extraneous living agents which are known must be excluded. Generally, the hazard of such extraneous agents is less in killed vaccines, since they are more readily detected and most often will be killed by formalin at the same time poliovirus is being killed. For these reasons, I believe it is obvious that killed vaccines offer a greater safety factor over the live vaccines.

Complications from Live Agents

There is both veterinary and human experience with live vaccines of other types. The veterinary use is indicated by the fact that live agents can be used usually with single doses and the immunity develops rapidly in most cases and, in some instances, no effective killed agent is known. There always has been some degree of "breaks" where the virus was too virulent and also there are instances where it was not virulent enough to immunize, so that there is a considerable degree of risk, both on safety and on effectiveness. Prier³² has reviewed these problems as they occur in the veterinary field. It would seem that the veterinary experience would not be a very good recommendation for the method in humans unless there were no safer and more effective methods available.

In the human, live agents also have met with considerable difficulty which seems to be inherent in the method. Live cowpox vaccine, for which there is now no substitute, causes significant diffi-

culties, sometimes serious.³³ We accept these as normal because smallpox is a serious disease and we have no other method of vaccination. Live yellow fever vaccine was contaminated with hepatitis virus and caused many severe cases of hepatitis during World War II.³⁴ At one point, the attenuated live yellow fever vaccine became virulent and caused cases of encephalitis.³⁵ Rabies vaccine, as developed by Pasteur, was a live attenuated vaccine. Today all rabies vaccines for human use in the United States are killed vaccines because there is significant evidence that the attenuated virus caused fixed virus rabies. I, personally, have had the unfortunate experience of losing a patient from this complication, where "fixed virus" was isolated from the brain at autopsy. Thus the history of use of live virus agents is strewn with significant troubles, and although they were relatively infrequent, they must be weighed into the general equation.

From this brief discussion of the problem, which is, to be sure, complex in its simplest form, it is obvious that we have made great progress in combatting the relatively uncommon but important disease of poliomyelitis. The problem may again arise, for we must not assume that the viruses we call polioviruses are the only ones to cause the syndrome of "paralytic poliomyelitis," since both Coxsackie and ECHO viruses have been found to cause isolated cases.³⁷ Epidemics of such cases may, in the future, be encountered. Vaccines probably will contain these viruses when it becomes obvious which of the many types are important.

The live vaccine is now being tried in epidemics in this country. It is possible that this will be a helpful procedure, and we await the results with interest. The indications are very strong that a diligent application of the killed vaccine will prevent most of the epidemics, just as toxoids did with diphtheria.

Conclusion

What do we finally conclude?

A formalin-killed, trivalent poliomyelitis vaccine has been safe and highly effective in preventing poliomyelitis. We know what its limitations have been, and there is good reason to believe that those limitations already are partly remedied and that further improvement will be made. We do not have, as yet, comparable evidence for safety and effectiveness of the live vaccines, and the use of them still is experimental

and highly controversial.³⁸ It would seem reasonable that if epidemics are permitted to occur by failure to vaccinate with killed vaccine, live vaccine could be tried for this purpose. There is now no certain evidence that the live polio vaccine will, in the long run, be as effective as the killed vaccine.

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About Our Cover

Our cover this month was designed by the Hungarian artist, Laszlo Balogh of Indianapolis, who created the cover for the April, 1961, Cancer issue. It is the universal hope that 1962 will bring further breakthroughs in prevention and cure of the many ills mankind is heir to. The Editor and Staff of the Journal would like to take this opportunity to wish all the Members a Merry Christmas and a Happy New Year.



The Case of the Hoarse Choir Singer

ARNOLD LIEBERMAN, M.D.

New York, N. Y.

MRS DORIS PRESLEY first came to us because she had continued with a "sore throat" that had not yielded to either the home remedies or the cough medicines given to her by the neighborhood physician. While she did not feel particularly ill her voice had begun to be affected. She was the leading soprano in her church choir; Christmas was near; she was anxious to have her vocal cords in prime condition.

There was nothing startling in the history. She had been born into a large Georgia sharecropper family. Since earliest childhood, she had helped plow a cotton field; she had had malaria, typhoid fever and hookworm. As an infant, she had been severely scalded by an overturned kettle of hot water. This had left one side of her face and neck badly scarred. She had had two years of desultory schooling; at fifteen, she had married and gone on to have four children none of whom survived the various ills of infancy. After a miscarriage, she had become "very sick" and had to be taken to the "white folks" hospital at the county seat. Apparently, a colpotomy had saved her life; however, her career as a mother was ended.

Mr. Presley served overseas during World

War II. He acquired the ambition to better his lot. After being discharged in 1945 he took his wife to New York; being a totally unskilled laborer, the best job he could get was that of a porter in an ancient hotel; his wife was lucky in being hired for a very menial operation on an assembly line for a clothing firm on 11th Street. They could just afford a dreary cold water flat up in Harlem; they bought a radio and watched TV occasionally. Their only socializing was done through the medium of the church they joined. Doris Presley became a devoted member of the choir; her pleasing soprano made her a natural for the solo parts.

The patient was a somewhat dumpy looking but a very quietly, neatly attired, light Negress in her early thirties; the clothing was threadbare but clean and well ironed; there was but little attempt at make-up; the hair was coiled meticulously into place and held in place by a snood. Her station in life was modest but definite and she meant to maintain it.

Careful physical examination was totally unrevealing. Vision and hearing were normal; the pharynx was clear; a quick look through the laryngoscope showed no abnormalities; the chest, abdomen and pelvis—all seemed to be

quite normal. The right side of the body was badly scarred by the ancient scald marks but the skin was freely movable over the underlying tissues. At 62", her 165 pounds were a good 40 pounds more than she needed but she had kept that weight ever since her pelvic surgery of many years ago.

The chest films, blood counts and chemistries, E.K.G.'s, urine analyses and other laboratory studies were normal. Doris Presley was sent to the laryngologist who thought that, possibly, the mucosa was slightly thinned and reddened in several places. He considered a possible diagnosis of masked avitaminosis: he prescribed vitamin injections, mostly B₁ and B₁₂, soothing sprays and gargles, strict abstention from singing until better, and (more as an afterthought) the loss of some weight.

Definite Denuded Areas

It was February before I saw the patient again. The recommended regimen had seemed to make her feel better but the voice had stayed husky; also, the laryngologist was distressed to note that—regardless of the torrent of vitamins being poured into her—her larynx now showed definite denuded areas. They were painless but, in his opinion, they had an ominous prognosis and he wanted a medical re-evaluation. This second examination, at first, seemed to be on its way to being as fruitless as the first had been. However, while looking at the chest, I observed a couple of scuffed blisters along the line of the straps holding her bra. They were small but still larger than anything I had ever seen as being due to such an insignificant cause. The nurse stripped Doris completely and we went over the skin focusing the spotlight area by area. Around her navel there was a definite excoriated area about 1 cm square. This *might* have been due to the friction of the tight rubber band holding her panties; this *might* have been, also, a positive Nikolsky sign, abnormally easy peeling of the skin *between* lesions. Anyways, the dermatologist was called in; he took some scrapings and found an abundance of fungi—the same as were found between the toes. He prescribed gentian violet dressings for the raw areas on the body and Whitfield ointment for between the toes. After the patient had left, however, he warned me that it just MIGHT be that we had been looking at the prodromata of dermatitis

herpetiformis, erythema multiforme bullosum, or even pemphigus.

Actual Symptoms Develop

Indeed, the caution was well-advised: within another couple weeks, for the first time, Mrs. Presley began to develop actual symptoms. She was "very tired," had begun to lose weight even without dieting, and she "felt foggy." Also, on her back there appeared a group of blisters that did not itch, were not scratched, and yet went on to form a regular cluster of bullae. The dermatologist was now willing to call the condition Dühring's disease, dermatitis herpetiformis. Rather obviously, in hindsight, the oral and laryngeal lesions must have been harbingers of the developing situation. The dermatologist was unprepared to rule out either erythema multiforme bullosum or pemphigus.*

The patient had been given mild soothing creams, anti-histamines, isonicotinic acid tablets as well as solid doses of sulfapyridine. It was all to no avail; the seriously ill Doris Presley had to be hospitalized. We were awaiting fresh lesions which we desired to biopsy; we also wanted to start a course of intensive cortisone therapy. Mrs. Presley was almost too obliging: the very day of her hospital admission she broke out with a massive generalized, bullous eruption; scores of phlyctenules covered her from head to heel.

One of these lesions was biopsied; the hospital pathologist reported unequivocally, "Dühring's Disease." However, our dermatologist examined the sections also and insisted on changing HIS diagnosis to pemphigus. His opinion was based on the fact that the lesion was mainly *INTRA*-dermal and that there was autolysis of the prickle cells of the epidermis; in dermatitis herpetiformis the primary lesion is *SUB*-epidermal. Later reading^{2, 3} rather makes me believe that the dermatologist was right. Ignorance being bliss, I am glad that our laryngologist did not come up with other possibilities^{4, 5} until much later: I did not worry about Behcet's Syndrome (aphthosis-oculo-oro-genital syndrome); also, we failed to consider the Stevens-Johnson Syn-

* At the time, none of us had read the excellent article by Obregon.¹ Like he, originally we had no knowledge of the Tzanck test or of the cantharides test and so were unable to substantiate our clinical impression.



... compelled to hire out as an extra maid at one of the shoddier Manhattan hotels . . .

drom (Hebra's erythema multiforme exudativum).[†]

Regardless of the *precise* diagnosis, Doris Presley was placed on ACTH, 40 units twice a day intramuscularly, three tablets of dexamethasone** every three hours around the clock, massive antibiotic therapy with tetracycline and penicillin, transfused twice and also given the more usual symptomatic therapy as a matter of routine. The precipitous downward course was checked and reversed. The lesions dried and disappeared; it was deemed safe to reduce the dexamethasone to two tablets q.i.d. and the ACTH to 40 units every other day. At the end of a month in the hospital, she was well on the road to a state of wellbeing. Antibiotics were discontinued and she was discharged for further office care only.

Deluge of Personal Problems

Poor Mrs. Presley, however, was confronted quite suddenly with a whole bevy of serious personal problems. The factory where she had worked "folded" even as she lay so critically ill in the hospital. It was one of those "run-

[†] Another pachydermic ponderosity concocted for this rarity is *ectodermosis erosiva pluriorificialis*. Tongue in cheek, I pass on this gem to all examiners of bright young specialists coming up for their boards in dermatology.

**0.75 mgs. of this fluorinated steroid is equivalent in strength to about 25 mgs. of cortisone. This daily dosage of about 600 mgs. of cortisone is not excessive when one considers dosages that can be administered on special occasions.⁶

away" plants that had hauled their entire plant to Mississippi; in that state there was a large labor reservoir at minimum rates—highly unionized New York could not begin to compete with such a bargain for the employer. Doris was out of a job; still, she continued coming to the office twice weekly for the ACTH injections. The dexamethasone tablets were reduced gradually to about three a day—anything less than this dosage tended to produce a re-appearance of the bullae, malaise, fatigue and all the other unlovely warnings of imminent danger. Antibiotics were not required any further. This tended to discount the theory⁷ of pemphigus that had been advanced at one time.

There was one extremely distressing feature of Mrs. Presley's ailment that goes absolutely unmentioned in all the literature on pemphigus that has come to my attention; yet, it proved the bane of the poor woman's existence. All the denuded skin areas, as they healed by re-epithelialization, became intensely pigmented a sort of shimmering deep blue-black. One can speculate that the melanin tended to be deposited by a process analogous to that seen daily in sunburn. Whatever the pathology, these iridescent blotches upon her very light chocolate skin made her look (and feel) like a spotted leper. Doris Presley became very despondent, refused to go looking for another job, and took to wearing huge, multi-layered veils when she would come to the office. She did look hideous and we could not really blame her for tending to become a recluse. We tried various cosmetic creams but nothing much aided her until it occurred to me to ask my daughter (who was spending a summer at the theater in the round) as to just what cream they used as a make-up base; this finally did mask the spots so that the woman could go out without having the feeling that she was a freak on exhibition.

In the fall Mrs. Presley's union benefits ran out. Compounding her worries, her husband got hurt while off work and found himself unable to continue toiling at the heavy labor which was his livelihood. Doris Presley was compelled to hire out as an extra maid at one of the shoddier Manhattan hotels. After deductions, her weekly check was less than \$40.00—not much for the back-breaking dirty work she was called upon to do. In order to get around the minimum wage laws, these hostelries hit upon the device of stating that the proffered job was "part-time"—

on a piece work basis. She was *supposed* to finish her assigned duties within FIVE hours (at the minimum legal rate); "strangely" enough, the *norm* was so calculated that a good worker could finish in nine hours, if not more. Previously, I had thought of *norm* as a particularly heinous device used by Stalin's minions to squeeze the last drop of effort from the proletarian brethren; apparently, some unscrupulous Manhattanites had been reading the same papers but had felt inspired to imitate rather than to condemn.

Anyways, it seemed only natural for me to suggest that Mrs. Presley apply to the appropriate city authorities for some relief benefits: food, clothing, rent and such. I'll never forget the response that my audible thought evoked. This poor, barely literate, ill, toil-worn, partially hungry woman—bowed deeply to the earth with worry, daily drudgery, and the incubus of a dread disease—drew herself up straight: Her eyes almost flashed as she spoke quietly but with unshakeable finality, "You mean well, doctor, but we did not come to this city for charity; we'll crawl to no one; we cannot be *beholden* to anyone for anything; I'd rather die first!"

Beholden!! Of course, the term is in rather common usage especially in the South. The slaves obtained the word from their masters who had brought it with them from England and Scotland. It does carry the connotation of being so deeply in debt as being almost *indentured* into servitude.*

Up to this point, Mrs. Presley had been just another extremely interesting diagnostic and therapeutic problem: a challenge to the medical profession's skill and acumen. Now, I was looking with sudden enormous respect at a real, human being. How did that unprepossessing body acquire such sensitive perceptions? How did this usually mute and uncomplaining drudge come into such an attunement with the Great Imponderables of Life?? It became—quite suddenly—a very urgent matter for me to really do what I could for her: not only medically but also personally.

Well: For one thing our office scrounged up some steroids for her; the ACTH we gave her

gratis: Our secretary made a discreet contact with the minister of her church; I also sicked on the Presley household a social worker I knew well (and to whom I had given due warning of the situation).

The minister came in to see me. He himself was old and ill. His parish was large and mostly indigent; he told me that he had been very worried about the Presleys; just the week before, Mrs. Presley had been talking with him. She had been very despondent; the reverend Mr. Best had been shocked to the very marrow of his bones when Mrs. Presley had told him that she had been thinking of stopping all treatment and "letting nature take its course." It was all he could do to point out the extreme sinfulness of such an even passive way of ending one's life. The harried cleric was most happy that he had had the chance to see me and discuss the Presley problem.



... took to wearing huge, multi-layered veils ...

* A very old Scotch escutcheon carries the word in the sense of being duty bound to serve, "beholden . . . should gie; the more noble, the more beholden." Of course, Doris Presley was using it in the usual association with slavery.

Emotions Aggravate Pemphigus

As a curious concomitant of the mental depression, I found that the dosage of steroid had to be increased enormously just to keep a step ahead of fresh bullous crops. While the literature was silent on this aspect of the disease, it was an indubitable fact that stress and emotional strain aggravated Mrs. Presley's pemphigus no end.

Almost two years after the initial hoarseness, there came the curious twist that makes the practice of medicine so endlessly interesting. My social service worker friend came in with a clipping from that day's *Herald-Tribune*; it dealt with the fact that an arbitration board had ordered the owners of the "run-away" factory where Mrs. Presley had worked to pay damages to their former employees. The owner was required to cover employees' wages, vacation payments and welfare contributions. While the money would not be forthcoming immediately, I was able to remind the union delegate of the woman's plight: we all got busy; before long, she had an advance on her back pay!

Also, we had dragged her husband to the office for an examination. His difficulties were absurdly easy to treat; our orthopedist outlined a course of treatment that rehabilitated him in no time at all. By Labor Day, he was back on his old job!

As the Presleys emerged from the financial mire, there came, *pari passu*, a spectacular improvement in Doris' condition. Fresh crops of bullae ceased marring her features; the old discolorations began to fade, rapidly merging with the surrounding, normally tinted skin. The amount of essential steroid was continuously decreased almost to the vanishing point—and she became evermore alert, vigorous and cheerful. Of course, the pemphigus may have run its course or, at least, have gone into a prolonged remission. This being the very first case I have ever seen recover, I cannot affirm or deny either way. Still, it is my very definite conviction that—in this one instance—the removal of stress had a very decisive influence on the spectacular come-back.

Be that as it may, by the end of October (a full two years after the initial hoarseness) the voice began to stage a recovery: It was the first symptom to appear and the last to disappear. The laryngologist insists that he can see no

difference from the first time he looked for an etiology for the harshening sound. In either case, Doris Presley is back in the choir and she expects to sing soprano solos this Christmas. The medical attendants are in hopes of discontinuing ALL treatment by then. I sort of have a hankering to sneak into a back row and so participate vicariously in the Return of the (no longer) *Hoarse Choir Singer*.

Also, I'd like to offer them a personal prayer against a recurrence. Not that I am particularly pious; still, it might be that the Good Lord would grant such a supplication. ◀

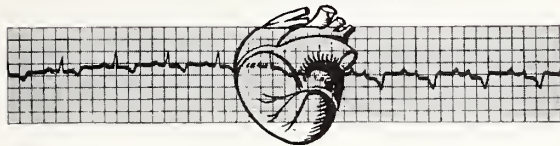
1270 Fifth Avenue
New York, N. Y.

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It was in that same year that I remember distinctly hearing a long presentation on the "bacillus of the common cold" . . . Where did these distinguished bacteriologists stray in their technics?

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Myxedema

CHARLES FISCH, M.D.
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THE NONSPECIFICITY of certain abnormal EKG patterns has been stressed repeatedly and it has been suggested that the significance of such changes be evaluated in the light of the clinical findings. It is the purpose of this report to present another condition in which an abnormal EKG may be present, the abnormalities being nondiagnostic (nonspecific) in nature.

In longstanding hypothyroidism the EKG may reveal sinus bradycardia, prolongation of P-R interval but most often the changes consist of diminution of the voltage of the QRS and T wave with frequent inversion of the latter. These changes can be considered as caused by myxedema only if administration of thyroid restores the tracing to normal.

A 59-year-old man was admitted to the Mari-

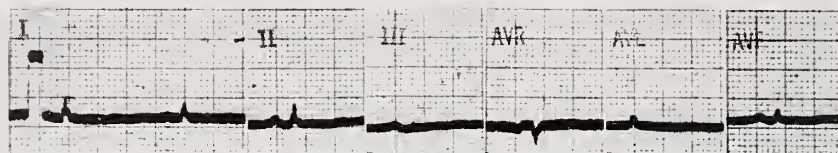
on County General Hospital, Nov. 19, 1953. The symptomatology, physical examination and numerous laboratory tests were consistent with severe myxedema. Electrocardiograms recorded on Dec. 14, 1953, disclosed normal sinus rhythm and a P-R interval measuring 0.16 seconds. The QRS complexes exhibited low voltage in limb as well as in the precordial leads. The T waves were either isoelectric or inverted in limb leads and of low amplitude in the precordial leads. Following institution of thyroid therapy the amplitude of T waves in all leads and QRS complexes in precordial leads increased in amplitude and the cardiogram became normal.

The exact cause of the decreased voltage is not certain. It does not seem to be a matter of increased skin resistance for subcutaneous as well as esophageal leads register the low voltage. The possibility of shortcircuiting of electrical potential within the myocardium as well as reduction of membrane potential due to generally depressed metabolism has been offered as an explanation for the observed EKG changes (Lepeschkin, E.: *Modern Electrocardiography*, Williams and Wilkins Co., Baltimore 1951, p. 323).

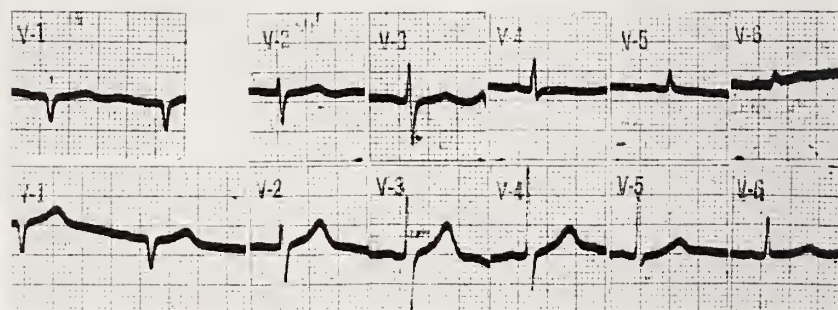
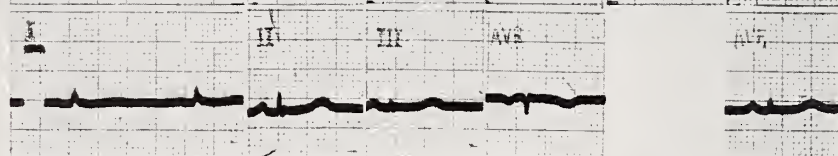
* From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health.

12-14-1953



3-7-1954



This figure represents the EKG before treatment (Dec. 14, 1953) and after treatment (March 7, 1954). For details see text.

LABORATORY MEDICINE

Published periodically as a review
of clinical laboratory procedures
suitable for laboratories with min-
imal equipment.

The Sulkowitch Test

*A. WENDELL MUSSER, M.D.**

THE IMPORTANCE OF CALCIUM in the homeostatic make-up of man's chemical equilibrium is well known. Calcium is important in man's neuro-muscular irritability, electrolyte balance, bone metabolism, blood coagulation and probably many other mechanisms unknown to us at this time. Calcium is an essential constituent of all living cells and extracellular fluid. The calcium of bone and cells is in a constant state of exchange with the calcium of the extracellular fluid. Calcium is interrelated with phosphorus.

Physiologically, individuals are usually in a state of calcium balance, ingesting and excreting approximately 500 to 800 mg. daily. Calcium is excreted in the feces and urine.

Various factors affect the absorption of calcium from the gastrointestinal tract. Among these are: (1) Normal pH—soluble calcium salts are formed in the presence of adequate hydrogen ion; (2) Adequate vitamin D which facilitates the absorption of calcium; (3) Normal digestion of fat—fatty stools tend to promulgate the loss of vitamin D and the formation of insoluble calcium salts; (4) Normal phosphate, for an excess would lead to formation of insoluble calcium salts.

The serum calcium, which exists in at least

two states, is not only affected by the factors listed above but also by the level of parathyroid hormone and serum protein level. One form of serum calcium is combined with serum proteins and is probably physiologically inactive and incapable of diffusing across capillary membranes. The remainder of the serum calcium is not combined and is diffusible. Ionized calcium is filtered by the glomerulus; therefore, the urinary excretion of calcium varies directly with concentration of the ionized fraction of the serum. Serum calcium is increased in such clinical entities as hyperparathyroidism, multiple myeloma, hypervitaminosis D, and many metabolic bone diseases. Serum calcium is decreased in hypoparathyroidism, pseudohypoparathyroidism, nephrotic syndrome, sprue, inadequate intake of vitamin D, and in many states that result in phosphate retention.

The Sulkowitch test has been widely used in disorders of calcium metabolism as an indicator of the presence or absence of hyper- or hypocalcemia. This test was first described by Barney and Sulkowitch in 1937. It must be stated that the Sulkowitch test is a rough rapid guide to the level of serum and urinary calcium. If more definite information is necessary for the diagnosis or treatment of a patient, the Sulkowitch test should be replaced, whenever possible, by quantitative determinations of urine and/or serum calcium concentrations.

* Formerly at Clinical Laboratory, Indiana University Medical Center, now at Womack Army Hospital, Fort Bragg, North Carolina.

Method

The principle of the test involves the addition of oxalate to urine and the formation of insoluble calcium oxalate. The type of precipitate, if any, is used to roughly estimate the amount of calcium in the blood serum. The Sulkowitch reagent is prepared by dissolving 2.5 gms of oxalic acid, 2.5 gms of ammonium oxalate, and 5 ml of glacial acetic acid in about 100 ml of water and diluting to 150 ml.

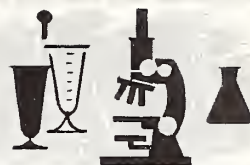
The patient should receive a diet containing only an adequate amount of calcium for about three days. Then collect a 24-hour specimen of urine and mix well.

To 5 ml of urine, add 2 ml of Sulkowitch reagent, one drop at a time. If no precipitate forms immediately, mix thoroughly and let stand for 10 to 15 minutes. Note the presence of any precipitate.

If no precipitate forms, the blood serum probably contains not more than 7.5 mg of calcium per 100 ml. If a fine white cloudy precipitate forms, the serum calcium is probably in the normal range of 9 to 11 mg per 100 ml. If a heavy, milk-like precipitate forms, the serum calcium is probably above normal.

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The Pathologist and the Microscopic Slide

ISSUE DIAGNOSIS remains one of the prime functions of the pathologist. His professional reputation depends on the accuracy of his reports. The most skilled pathologists make the fewest mistakes, but it is inherent in our scientific discipline that occasional errors of omission or commission will occur. Morphologic character does not always coincide with biologic behavior of a given lesion. Experience has shown that the rules of our "game" are valid with a high degree of certainty. Yet the rare case may present itself which will seemingly make fools even of the most learned pathologists.

The pathologist is the most frequently used medical consultant simply because every slide is in fact, a consultation. The surgeon is asking for help, or confirmation, on a given surgical specimen. While there may be no direct personal communication between surgeon and pathologist, in any given case, the pathologist's report constitutes a written consultation, for the record. In order to be of maximum value, this consultation pre-supposes complete pertinent information is given the pathologist, by the surgeon, as to the clinical history, physical examination, operative findings, clinical diagnosis etc. This may be done by a personal talk between the two, or by written information on the tissue sheet accompanying the specimen. Only in this way can the pathologist be of maximum value to his colleague, and through him, to the patient.

The microscopic slide constitutes the permanent though fractional remnant of the gross specimen. It is numbered and filed in such manner as to be easily available at some future date for review, for statistical studies, for consultation, or for teaching purposes. Each pathologist strives to achieve that degree of technical excellence in the preparation of the tissue sections that will assure easier study and interpretation. Each

slide then becomes a "work of art," representing a hand-crafted monument to the skill of his tissue technician. The pathologist is always anxious to display to his professional colleagues the beauty of his microscopic slides and to discuss the case in the light of the histologic findings. In this way both surgeon and pathologist benefit by mutual interchange of knowledge. Duplicate slides of rare and/or interesting lesions are usually cheerfully made and given to any interested physician.

What does a pathologist do when he is puzzled by a given slide and cannot reach a diagnosis? Pathologists approach this problem in various ways. Intelligent course of action dictates, first, the preparation of additional sections from the original paraffin block, additional wet tissue cut for processing, and the use of special stains which may clarify the problem. Personal communication with the referring physician may also help. If, after all these means still leave the pathologist in doubt, he naturally turns to others for help. Consultation with other pathologists is a ceaseless activity, indicating not ignorance or incompetence, but the search for truth. The only pathologist who never made a mistake is he who never referred any of his cases to another for consultation.

There are pathologists of stature who constantly are bombarded with unusual or puzzling cases from their friends seeking help. It has been my experience that practically without exception gracious consultation service is given, without recompense. In this way the patient is assured of the best available talent, at no additional cost.

It is obvious that the younger the pathologist the less his experience. He will be more prone to seek help than one more mature. Time will give him that measure of confidence which only

experience imparts. Slide referrals are especially indicated in cases where major or disabling therapeutic procedures will be done if a diagnosis of malignancy is made. I have reference here to cases of grave prognostic import, where pathologists often differ in individual interpretation. Such lesions as early Hodgkin's disease, in situ carcinoma of the cervix, carcinoma of the thyroid, questionable adenocarcinoma of the endometrium, malignant melanoma, etc. are all in this category. It is always comforting to have someone else review the slides in equivocal cases. Only in this way can accurate diagnoses be made. It happens occasionally that on a given slide several consultants may return various diagnoses. This only bespeaks the complexity of the art and not faulty reasoning of the pathologist. A

diagnosis cannot be made by "plebiscite," and there are times when reputable authorities disagree. The entire episode must then be related by the original pathologist to the surgeon and a decision made as to the most reasonable course to follow.

A plea is hereby made for closer liaison between pathologists and surgeons. Only in this way can the problems of both be lessened and the welfare of the patient enhanced. A pathologist incurs no disgrace or dishonor when he is asked to refer his slide to another. Most pathologists will be the first to suggest this procedure. But all will do so, for only in this way can all be assured that the very best of medical knowledge is being used for the patient's welfare. ◀

The Journal of the
Indiana State Medical Association
MEDICAL ESSAY CONTEST

for
Interns and Residents of Indiana Hospitals

During the intern and resident year of 1961-62 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of \$100.00, a second prize of \$75.00 and a third prize of \$50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1962.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

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Abuse of Physicians' Drug Samples

THE MAGNITUDE of the problem of the sale of physicians' drug samples is illustrated by the latest seizure by the Food and Drug Administration of 30 lots of drugs in 10 states to an estimated value of over \$500,000.

Commissioner George P. Larrick commented that gross carelessness had been found to characterize the handling, repackaging and selling of sample drugs. He reports abuses such as:

- (1) Disregard for the expiration dates of antibiotics.
- (2) Mixup of drugs not only as to identity but also with respect to strength.
- (3) Destruction of essential labeling containing directions, warnings and precautions for the safe and effective use of the drug.

In addition to the above liberties taken with prescription drugs inspectors have found drugs intended only for investigational use on drug store shelves, and apparently subject for sale for use by persons other than those conducting research.

Mr. Larrick has recommended that manufacturers supply physicians only with the drugs they want and will use, that physicians accept samples only when they intend to use them and that physicians destroy all samples that they do not use.

The Commissioner also advises that no one should supply retail pharmacists with physicians' samples and that the pharmacists should not dispense such samples in filling prescriptions.

To further control investigational drugs the drug firms are advised to improve the system of control over such drugs to be certain that unused supplies are destroyed, and that anyone engaged in research should also destroy unused investigational drugs.

In publicizing the seizure of the illegally handled sample drugs, and in outlining recommendations for improvement of the situation Mr. Larrick emphasized that the Food and Drug Administration does not intend to interfere in any way with the legitimate distribution of samples to physicians.

He has also acknowledged the custom of the

supply of free prescription drugs by manufacturers to retail pharmacists, but pointed out that such supplies should be in the form of regularly labeled and packaged products and not physicians' samples. He reported that a number of pharmacists had voluntarily destroyed physi-

cians' samples when inspectors informed them that such samples should not be sold.

The large-scale seizures have apparently been directed to retail drug outlets not availing themselves of the privilege of voluntary destruction of samples.

Gallbladder Surgery*

WITH THE DEVELOPMENT of cholecystography the diagnostician has been able to make an accurate diagnosis of gallbladder disease. Further development of intravenous and operative cholangiography has enhanced the diagnosis of major bile duct involvements in a variety of pathologic conditions.

Surgery of the diseased, malfunctioning or stone-containing gallbladder has been uniformly gratifying.

Major considerations in gallbladder surgery have evolved into proper evaluation and preparation of the patient and into avoidance of technical errors during the operation.

The surgeon should always be aware of the possibilities of *anomalies* and variations. Inasmuch as radiographic visualization depends upon a functioning organ it is not likely that he will be forewarned.

There is uniform agreement that there is no substitute for adequate exposure and the unqualified demonstration of common and cystic

ducts and the cystic artery or its branches in the routine cholecystectomy.

Vascular clamps to temporarily occlude the hepatic artery, approached through the lesser peritoneal cavity, are of considerable aid in the control of hemorrhage as a means to avoid "blind" clamping or suturing in the region of the hilum where bile duct or major arterial injury may be of grave consequence.

Removal of the acute gallbladder presents additional hazards of technical nature. It is wise to avoid dissection in the region of the common duct when the area is markedly indurated. In that event a simple cholecystostomy after removal of stones may be the better part of valor; or an intravesical dissection down to the cystic duct will avoid injury to the vital structures of the portal triad and makes for easy control of branches of the cystic artery.

Finally as the procedure is terminated it is well to place some fatty tissue into the area of the gallbladder bed and to routinely provide adequate drainage by Penrose drains from the region of the foramen of Winslow.—George M. Johnson, M.D., Richmond.

* Reed, E. S., Carlberg, D.: Gallbladder Anomalies, with Report of a Double Gallbladder, p. 1780.

Where Ribicoff Stands

ON SEPT. 13, the Secretary of Health, Education and Welfare, Abraham Ribicoff, gave a statement to the Senate Subcommittee on Antitrust and Monopoly on the Kefauver-Celler bill to regulate the drug industry. The voice was the voice of Ribicoff; the statement was prepared in conference with the agencies under his jurisdiction that will bear the ultimate responsibility for enforcing the legislation that may eventually be enacted.

Everyone assumes, and no doubt rightly, that the present version of the Kefauver-Celler bill cannot possibly become a law. Indeed, Secretary Ribicoff did not give his consent to some of its provisions, his primary concern is the cost of

drugs. But far more investigation of the figures underlying these costs is needed before any legislation can correctly reflect the situation.

The Secretary also decries the fact that many pharmaceutical manufacturers imitate successful products introduced by other manufacturers. And in the next breath he condemns monopoly of any product by a manufacturer. He condemns—and I fully agree with him—extravagant advertising and untruthful promotional campaigns. The question is why have not existing laws been sufficient to prevent these abuses.

I believe the difficulty has been not with the laws but with the utterly inadequate funds allowed to the enforcement agencies for the en-

forcement of those laws. However, any new legislation that would hinder the pharmaceutical industry from spending what it now spends on research would inhibit medical progress. And legislation that would consider the drug industry as unique from any other industry in its patent privileges would inevitably damage American pharmaceutical progress.

Secretary Ribicoff had much to say about two other matters: the naming of drugs and a need for proof of effectiveness before a product is granted a license by the Food and Drug Administration. After some 50 years of experience in this field, I would caution any individual or agency against becoming too greatly involved in the question of proving effectiveness.

In my years of association with the Council on Pharmacy and Chemistry of the American Medical Association—whose unfortunate demise no doubt helped to give rise to the current situation—I can remember innumerable instances in which the 17 recognized authorities, including every phase of chemistry, pharmacology, biochemistry and medical practice found it exceedingly difficult to establish the effectiveness of a remedy.

A remedy effective in one dose for one person may be poisonous in the same dose for another. People are not capable of standardization; the

response of the living body is a highly variable factor.

There are other points which need to be carefully considered. For instance, Secretary Ribicoff feels a new drug should not be allowed on the market until HEW has determined that it will be safe and effective in the diseases and under the conditions of use for which it is offered. One can anticipate the months, or even years, of delay that might ensue because a timid Secretary hesitates to risk his political future in releasing a drug about which there might be a shadow of a doubt. Had such a law been in effect in the past, it is possible that many millions of persons would have died unnecessarily of the conditions controlled by insulin, penicillin, the sulfonamides, diphtheria antitoxin, and many, many other drugs widely used today.

On certain other matters, however, one cannot possibly disagree with Secretary Ribicoff. There may be instances of abuse in labeling, in exploitation and in promotion of drugs. There may be evasion of existing laws in this field as in other fields. However, the sweep of indictment is far too broad. Perhaps the ultimate legislation will constitute something more resembling a rifle aimed at a target instead of a blunderbuss that scatters shot far and wide without being quite sure as to what is intended to be destroyed.—Morris Fishbein, M.D., reprinted from *Medical World News*, Oct. 13, 1961.

Dignity in Dying

WE HAVE ALL stood beside the dying patient. The feeling of futility that sweeps over us at this time is profound and depressing. We are faced with a decision; shall we strive to use extraordinary measures to keep him alive? Or shall we make his going out of this life more comfortable, not adding to his misery by tubes protruding from every orifice nor by needles poked into veins. Perhaps it is wiser to let the patient's comfort be paramount, allowing him relief from pain and other discomforts. The family wishes to be close by waiting for the conscious moment to hear a last word from the dying. We must not lose sight of this. We can stand by unobtrusively not intruding on the last intimate touch of love.

While the patient is still conscious, his every desire should be fulfilled. Our daily visits to him, listening to his complaints and the positive

approach to the relief of his anxiety helps him to feel we still care. This gives the dying patient the sense of still being a human being. Further encouragement comes from the routine nursing care. The patient realizes he still exists and is not passed by for the non-dying patient.

This editorial is not an argument for doing nothing in cases of the dying. It is a plea for compassion and understanding in those cases that are irreversible and inevitable, no matter what is done. No doctor gives up until he knows he has lost.

The fear of death is great. Religious solace can ease this fear, but to give dignity to death we must not let our patient die alone—without the presence of his family, friends, his minister and his doctor.—G. N. Lewis, M.D., reprinted from the *Lake County Medical News*, Oct., 1961.

Editorial Notes . . .

The Lionel Corporation, through one of its subsidiaries, has perfected a "Home Owners Radiation Meter" which measures radiation inside a fallout shelter, and by remote control in three other locations connected to it by wires. This allows the owner a measure of satisfaction if the radiation level in his shelter is safe and also informs him when it is advisable to emerge. The instrument reads true regardless of the length of wire to each outside station. It may be disconnected and carried as a portable meter outside.

The type of life insurance that may be obtained to guarantee the payment of a loan is big stuff. Last year one death payment out of nine was made on credit life insurance. The money involved is not at such a high ratio; it amounts to 4% of the total life payments. \$140,000,000 was paid out in 1960 by all the life insurance companies in the U. S. Credit life insurance is increasing; it not only relieves the surviving family of the debt but also assures the lender of a full repayment.

Dr. Rene Dubos of the Rockefeller Institute, in an address before the Association of Life Insurance Medical Directors of America recently described the changes which have occurred in microbial diseases during years just past. In the 19th century infectious diseases were acquired from contaminated food or water or from some sick person. We now know how to avoid this type of infection and as a result the mortality from microbial diseases is very low. On the other hand the morbidity of in-

fectious disease is still high and accounts for the greatest portion of absenteeism from school and work. The viruses or bacteria which cause disease today are largely normal and non-disease producing inhabitants of healthy persons. Whether the host becomes sick depends not on the organism but on some condition within the body which allows the organism to produce disease.

Liquid pre-game meals are good for football players. The University of Nebraska investigated the effects of a 10 a.m. liquid meal of Mead Johnson's Sustagen, following an early breakfast of toast, honey and peaches. The effects were so good that the players voted to continue the dietary regimen. In contrast to solid food, the liquid meal had departed the stomach by game time. Pre-game nausea and vomiting were eliminated. The players showed improved strength and endurance. Complete details are presented in the October 7 issue of the *J.A.M.A.*

Fire loss in the U. S. in 1960 set a new record in destruction of life and property: 11,350 Americans killed, the most ever. Over \$1.5 billion worth of property was lost. Hospitals, churches, office buildings, warehouses, grade schools and aircraft had better records than in 1959. Residences, college buildings, retail stores and motor vehicles were burned enough more to make the total loss a new high. Principle causes are listed as careless smoking, defective heating and cooking equipment, electrical defects and mishandled flammable liquids.

Effective Communication

In a poll of the nation's doctors sponsored by the American Medical Association in 1958, 68% of the physicians interviewed stated that the detail man was their chief source of product information. Since detail men are also our most costly means of communication, we cannot rely on them entirely. Contrary to what some legislators and others would have the public believe, it is the aim of pharmaceutical companies to spend *as little*, and not *as much*, as possible on the promotion of their products while still maintaining effective communication with the medical profession.—T. F. Davies Haines, President, Ciba Pharmaceutical Products Inc., to Association of American Medical Colleges.



Can't Indiana Help India?

*M*ANY PHYSICIANS, their wives and guests were impressed during the October convention of the State Medical Association by the display depicting health services activity in the Udgir District of Bombay State, India—and were touched by the need for medical and surgical equipment in the poverty-stricken area.

The booth was set up and manned by Dr. and Mrs. Burleigh Matthew, assisted by Mrs. Dennis Megenhardt and Dr. and Mrs. Morris B. Paynter. Dr. and Mrs. Matthew and Dr. and Mrs. Paynter have long been interested in the program, particularly since they and a group of 22 completed a trip around the world in August, 1960. At this time they came to realize the poverty, the want and the need of the rest of the world.

Before making this trip, Dr. Matthew had been instrumental in raising funds to build a medical dispensary in Udgir, India, which is a small village of about 15,000. At that time the nearest hospital, physician or nurse was a distance of some 135 miles, a six-hour trip by jeep. On the tour Dr. Matthew had the honor of laying the cornerstone for the first crude building and he was appalled by the desperate need for anything and everything. He found that the non-medical missionary Rev. Paul Wagner and his wife Mabel, who are supported by his church, Broadway Methodist of Indianapolis, were treating some 500 lepers with medicines sent from the United States through church funds, and this number was increasing daily.

Since this group visited Udgir many wonderful things have happened there. A young mis-

sionary ophthalmologist, Dr. Raleigh Pickard, has been sent to this District and Dr. Matthew immediately spearheaded a movement which already has resulted in the forwarding of more than 1,500 pairs of glasses to the Udgir District dispensary. Several children have been adopted and are being educated by the Americans who were on this tour, and now four buildings are near completion for the medical dispensary. But, as yet, the dispensary lacks all types and kinds of medical and surgical equipment.

Funds are needed also for the shipment of such materials and supplies. Checks for this purpose, made payable to Broadway Methodist Church and earmarked "India Equipment Fund," may be sent to Dr. Matthew at 518 Hume Mansur Building, Indianapolis 4.

The needed surgical and medical supplies may be sent to either Dr. Matthew or to Dr. D. S. Megenhardt at 1633 N. Capitol Ave., Indianapolis, who will arrange for their shipment to India.

"The need is so great," Dr. Matthew explained. "Doctors are on hand in the District but they have very, very little with which to work. There are many thousands of persons in the area—which extends in all directions for about 80 miles—and they are in dire need of medical help which cannot be given properly unless equipment is available."

All gifts of cash or equipment will be acknowledged, Dr. Matthew stated.

Needed equipment includes such items as portable autoclave (non-electric), instrument boiler (non-electric), Tycos blood pressure apparatus,

Reiger-Bowles stethoscope, oral and rectal clinical thermometers, 2,5,10,50c.c. B-D syringes, tuberculin syringes, 2 and 4 ounce Asepto syringes, Yale BD needles 18, 20, 23 and 26 gauges, three-way stopcocks, Guedel rubber airways (adult and child's), Yankauer mask, Young tongue holding forceps, straight scissors, curved scissors, Mayo dissecting scissors, Lister bandage scissors.

Also Pean hemostats, straight and curved mosquito forceps, straight and curved Kelly hemostatic forceps, Blunt forceps holders, Kocher hemostatic forceps, Backhaus towel forceps, Mayo-Hegar needle holders, Sponge holding forceps, Allis tissue forceps, Vaughn sterilizer forceps, mouse tooth tissue forceps, thumb dressing forceps, drainage trocar, Roux double ended retractor.

There is also need for B-P instrument containers, regular surgeon's needles, sizes 3, 5, 7, Keith abdominal needles sizes $2\frac{1}{2}$ and $3\frac{1}{4}$, Mayo intestinal ($\frac{1}{2}$ circle) needles sizes 3, 4, 6, Mayo intestinal needles straight sizes $2\frac{1}{2}$, gooseneck lamp, adjustable crutches, Thomas leg splint—full ring, Vienna nasal speculum, Jansen bayonet dressing forceps, Jennings mouth gag, La Force adenotome, Eves tonsil snare, White tonsil forceps, Hurd tonsil dissector, Hirschman anoscope, Circumcision clamp, male catheters, Graves vaginal speculum set, Hegar

dilator set, Sims uterine curettes, Skene vulsellum forceps, obstetric forceps, Collyer pelvimeter, De Lee pelvimeter, De Lee mucus traps.

Also Smellie perforator, Kelly surgical pad, glass supply jars set, thermometer jars, adult bed pans, stainless steel male urinals, Vollrath irrigators, pus basins, solution bowls, sponge bowls, needle jars, ointment jars, iodine cups, sterilizer pans, catheter trays, instrument trays, Mayo stand, water pitchers, graduated measures, utility jars, forceps jars, oval foot baths, rubber sheeting, invalid cushions, Davol breast pumps, intravenous tubing, polyethylene tubing, surgeon's gloves, Foley catheters, Phillips urethral catheters, Filiforms, Olive tip catheters, Bardex catheters, Davol Levin tubes, stomach tubes, oxygen catheter (12Fr).

Dr. Matthew pointed out that "here is an opportunity for doctors who have items of equipment for which they no longer have use to put them to humanitarian beneficence. Also, there may be supply houses which would like to participate in this Christian program of self-help.

"We will be most grateful—but, more than that, there will be the lasting gratitude of these people who need the service so badly."

Dr. Matthew points out that should equipment in excess of need be received, the surplus will be sent to Methodist Hospital, Kapanga, Congo.

Reversed Spirit of Independence

It cannot be denied—the record demonstrates it incontrovertibly—that social concepts and programs which originally were embraced to help people to help themselves—and thus to preserve in them a spirit of independence and self-reliance—have been progressively distorted and modified so as to, thwart and stifle those saving attributes in our citizens and to develop in them instead a despicable eagerness to depend and rely on government.—*North Carolina Medical Journal*, Oct., 1961

President's Page

CONVENTION IN RETROSPECT

The 112th Annual Meeting of the Indiana State Medical Association is now history and it might be interesting to discuss some of the events from one's personal observations. The official happenings of the Convention will of course be printed in detail in the *Journal* but this short discourse will be an attempt to editorialize.

The meetings of the Council and the two meetings of the House of Delegates went off as scheduled and in my opinion without significant controversy except in a couple of matters. There were a few spectators at each of the House meetings but not nearly as many of the members as I would like to see attend these meetings. Each member of the ISMA must remember that he may attend these meetings as a spectator and each member is urged to do so. The Reference Committee meetings were fairly well attended this year and in my opinion this is a good sign of interest in the matters of the Association. I shall refer to this Reference Committee attendance a little later when I mention the scientific program.



We were honored by the presence of Dr. Leonard W. Larson, President of the American Medical Association, who spoke to us in the main theater of the Murat Temple and also attended our annual President's Banquet. Dr. Larson had an attentive audience for his speech but the number present left much to be desired.

The President's reception and Annual dinner were gala affairs with an overflowing crowd at each and I interpret this in part as a tribute to the tremendous amount of work Dr. Owsley has given to our Association. Also I want to again compliment Dr. Owsley on his address given that evening and which is printed elsewhere in the *Journal*.

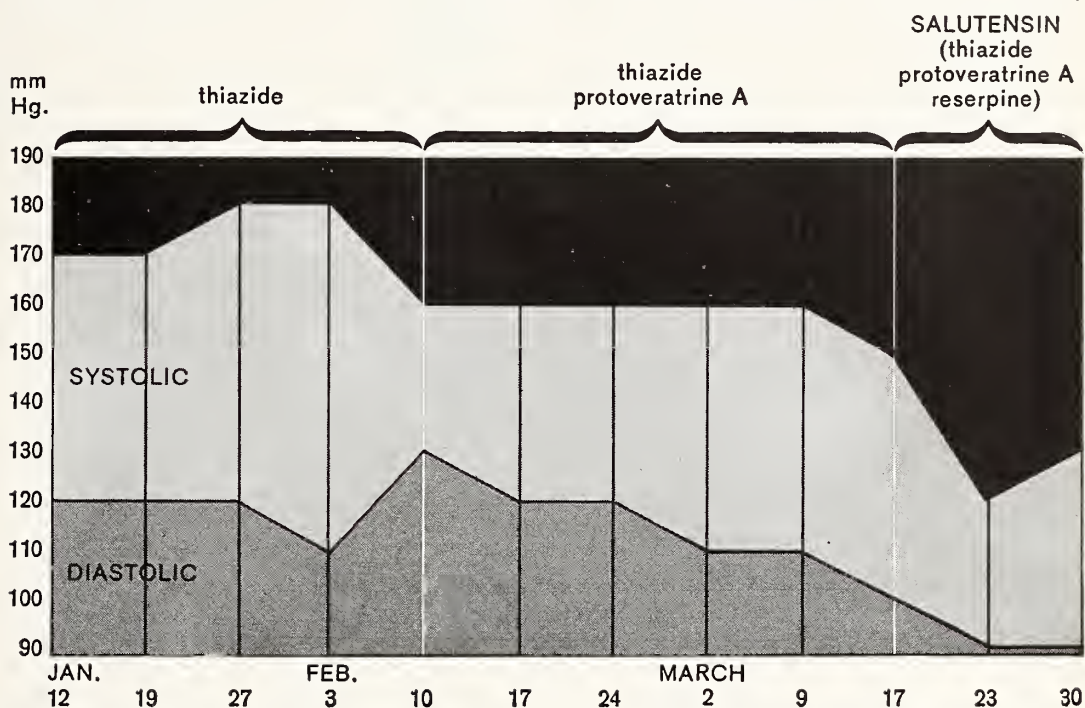
A special event at noon on the last day of the Convention was the laying of the cornerstone at our new Headquarters Building at 3935 N. Meridian St. We expect to have occupancy of this building sometime in April or May of 1962.

The Technical and Scientific Exhibits make up a large part of any medical convention and our meeting this year was no exception. The Technical Exhibits were numerous and fairly well attended.

Continued

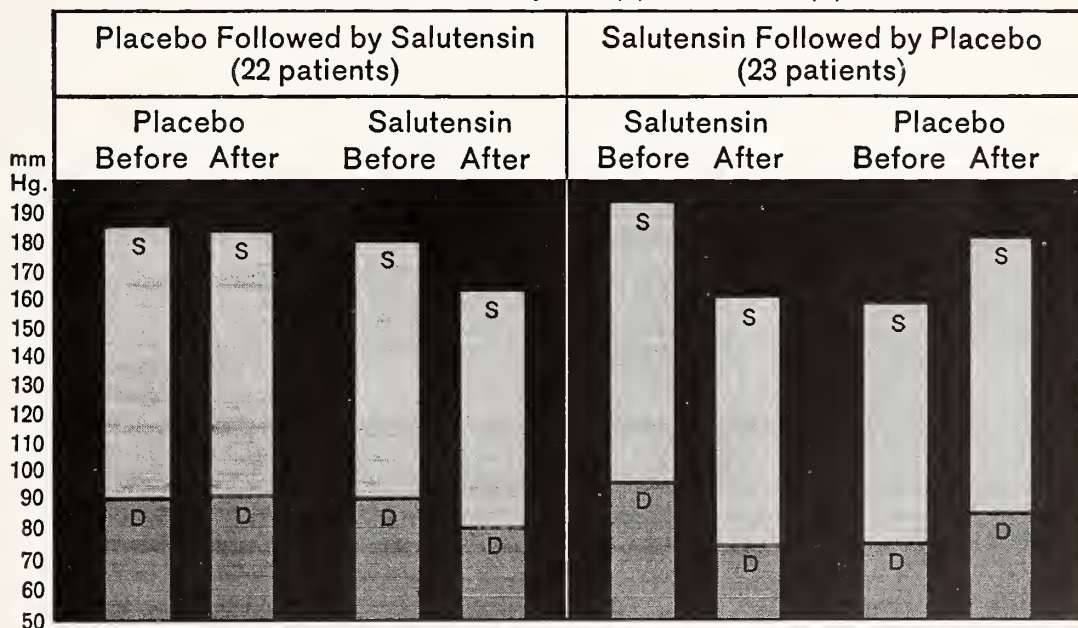
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.



Clinical Research in the Pharmaceutical Industry

ROBERT K. CUTTER, M.D.*

Berkeley, California

WITHOUT CLINICAL TRIALS, pharmaceutical research would come to a standstill. Animal testing helps eliminate hundreds of hopeful product-candidates developed in the laboratory. It can point out the possible useful attributes of the few remaining. But, despite the years of patient research effort that may be behind any drug prior to tests on humans, there can be no real prediction of its value, other than the probability of failure, before human clinical testing.

It takes time. It is costly, and it requires the interested collaboration from individuals in clinical medicine.

What then is the problem of the pharmaceutical industry? It is simple in its description: We synthesize or otherwise develop a new drug or agent. Our laboratory chemists may be able to tell us that the formula of this drug shows certain conformations which might endow it with certain desirable pharmacologic or physiologic properties. Perhaps our pharmacologists find that the drug does have desirable activity in animals (though not necessarily the activity predicted by chemists). Does it then have the same, or even any useful activity in humans? We

must try it and see. This is the job of clinical investigation.

In most pharmaceutical companies there is a separate department of clinical investigation. The scientists in this department assemble the basic information available concerning the new agent, review clinical aspects of the pathologic condition for which this drug might be effective, and study efficacy (or lack of) available therapeutic measures for this clinical problem. As a result of this research, a program for its clinical trial, utilizing the services of appropriate consultants, is proposed. Usually these consultants are those physicians who, after having learned of the new agent, have indicated their interest in conducting the clinical trials, and have adequate clinical material and facilities at their disposal. When the program is resolved, financial support is arranged for necessary costs which may be involved and the study is begun.

Costly Toxicity Studies

However, simple the problem may seem when condensed to its descriptive summary, it is by no means elementary in its execution. An important responsibility of the pharmaceutical company in the early clinical trial of a new therapeutic agent is to reduce or clarify, as far as possible, any potential hazards of the test. This obliga-

* President, Cutter Laboratories, and a director of the Pharmaceutical Manufacturers Association.

tion is met only after extensive toxicity studies and pharmacologic observations have been made in several species of animals.

These tests are expensive because of the rising costs of personnel, animals and supplies. This is of more than passing interest to the physician. It is now so costly to put a drug through toxicity tests alone that the pharmaceutical company must demand that the field of potential usefulness of the drug—if it does prove to be effective—be very real and broad in order to justify even commencing the studies. Nevertheless, practically every well known ethical pharmaceutical house has introduced drugs which are not profitable and which have a very limited field *but* are the only useful products for an uncommon condition or are life savers.

I certainly hope that hastily and ill-conceived laws will not erect such terrific roadblocks that these products, doomed to economic failure because of their limited use, cannot be produced by pharmaceutical laboratories in the future.

As soon as the toxicity studies on a new drug have indicated that it is safe to use the agent in humans, clinical trials are undertaken. Arrangements for these trials usually are first made with one of the several medical schools or major hospital groups in the country engaged in human drug therapy research. These trials are initially exploratory in nature and are conducted under very close medical supervision. In the case of a new compound, the initial studies are customarily devoted to dosage range studies and to human pharmacology.

In this phase paid volunteers are used—medical students and laboratory workers who offer their services—or volunteers from certain groups that have an interest in the outcome of the drug trials. These persons are observed carefully during the trials and the total number of single doses each receives is increased very slowly. It is at this stage that the dosage limits are ascertained and the evidences of over-dosage are characterized. When a reasonable dose is decided upon, certain functional studies are undertaken. At this time such studies as blood clearance and urinalysis for the compound or its metabolites are done. Observations are made primarily to detect alteration of function similar to those found in the animals when the drug was administered during its pharmacologic trials. However, the investigator must always be alert to other unanticipated changes.

This stage of the clinical trial is a most exciting one. It is the time when we collect the information enabling us to decide whether or not the new agent under study merits the time and effort which have already been invested in it. We must now answer the question: Does it justify further development?

Therapeutic Use of New Drug

Following this phase there is a critical review of the therapeutic possibilities of the drug. From the human pharmacology studies, together with the larger background of animal studies, a forecast is made. Which, if any, pathologic clinical states are most likely to be favorably influenced by the drug? Is it likely to fulfill a need not now attained by drugs already available?

If this review results in a decision that there is an appreciable need for such a product, additional careful and long-time clinical trials are undertaken. Numerous toxicity studies directed at certain effects, which may have been uncovered during the human pharmacology trials, may also be needed.

The results of the human pharmacology trials, or of initial human pilot studies, together with those of the animal pharmacologic data, determine the pattern of the final clinical trials. The clinical pharmacologists who conducted the initial human tests, and the medical staff of the pharmaceutical house, evolve an expanded program. Skeleton protocols are designed at this stage. Expansion of the program usually provides for placing the new agent in a variety of clinics or health departments sufficient to prove or disprove its utility for the purposes suggested by the preliminary studies.

In addition to potential new drugs, we still have the various pharmaceutical mixtures of old drugs. Many new examples of these offer real advantages of pharmaceutical excellence in taste or convenience. Good ones must still be tried clinically. Although these are often of little interest to ivory tower academic scientists, they are frequently of real importance to practicing physicians.

Clinical Trials by Physicians

The clinical investigation department of a pharmaceutical manufacturer often goes directly to the practicing physician for clinical trials on this kind of a preparation. Surprisingly, this solution is proving to be an extremely appropriate and happy one for all concerned. For one



CLINICAL RESEARCH

Continued

thing, the company obtains not only the clinical information it seeks but also a much earlier evaluation of the degree of usefulness of the drug to the practitioner. On many occasions the director of clinical investigation is able to abandon a product early in the trials because of some practical reason quite apart from its effectiveness or lack thereof.

Most of the clinical trials conducted by pharmaceutical company scientists are undertaken to explore the possible uses of new agents. However, a sizeable number of trials are instituted to prove that certain minor changes in the manufacture or packaging of an agent have not altered the effectiveness of it.

Results of any clinical studies are published by the investigator performing the study. One of the cardinal principles on which this joint venture of the clinician and the pharmaceutical firm is

founded provides that if the investigator decides that the results of the investigation justify publication, he will be free to publish whether or not the published report is favorable to the new agent. All reputable pharmaceutical companies insist on this basic principle.

From this discussion it should be apparent that the task of sponsoring clinical trials on a new drug is prodigious. This results in an increasingly critical review of a potential new drug by the pharmaceutical company management prior to any decision to develop and market it. This is an important fact to bear in mind when considering proposals which will greatly reduce patent and trademark protection for pharmaceutical houses such as those recently made to the Congress in proposed legislation.

While clinical research is extremely costly, it is by no means the major factor in expenditures for drug research. For every new drug or agent developed by chemists and other pharmaceutical laboratory researchers that reaches the clinical investigation stage, hundreds, after careful testing and animal pharmacology, are discarded prior to human pharmacology studies. Still more are dropped following this stage. Intensive human clinical investigation results in many additional eliminations before even a single successful drug is developed. The staff of the Pharmaceutical Manufacturers Association has computed, on the basis of questionnaires to the drug industry, that the failure ratio of drug substances tested in 1959 to those reaching the market was 2505 to 1.

Against these odds, does it seem likely that even a single major drug firm can carry on even a small fraction of its current research if, when it does finally develop a successful new drug, it is allowed no trademark protection and must license any and all competitors who wish to ride on its "research coattails?" If free enterprise in pharmaceutical research is stifled, the medical profession will suffer, but the patient will be the loser. ◀





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In '62—Unity and You

Delivered Before the Annual Meeting of the
INDIANA STATE MEDICAL ASSOCIATION,
Indianapolis, October 25, 1961

LEONARD W. LARSON, M.D., *President*
American Medical Association

ABRAHAM LINCOLN, a rather well-known American who lived for a while here in Indiana, once gave the nation this immortal advice.

"If we would act anew, we must think anew, and disenthral ourselves from the outmoded beliefs and actions of the past."

I think all of you would agree that Lincoln could hardly be described as a radical or a left winger. His heroic leadership in preserving the Union demonstrated his profound faith in the traditions and principles established by our founding fathers. At the same time, he was able to look ahead and recognize the potentialities of new ideas and new methods.

Today, his advice is more pertinent than ever—for the entire nation and for us in the medical profession.

We physicians have both the right and the duty to fight for the preservation of those traditions and principles which we believe are essential to good medical care and continuing medical progress and good government. However, we shall be ineffective if we simply confine our efforts to opposing changes or trends which we may not like. We too must be able to look ahead, anticipate problems, explore new approaches, and develop improved methods of serving our patients and the public.

To do this we first should take a good look at our past beliefs and actions. Are we, as individual physicians, going beyond the daily practice of medicine and taking some part in the

affairs of our profession, our community and our nation? Are we, as medical organizations, stimulating and mobilizing the profession's full potential for constructive effort to promote the public welfare?

Fortunately, thousands of physicians and many medical societies could answer those questions in the affirmative. Nevertheless, we must face the fact that we have a lot of work to do in firing up a sense of alertness and participation by both individuals and medical organizations.

In this connection, and with the forbearance of any of you who may have attended the recent AMA Institute in Chicago, I should like to repeat and re-emphasize a point I stressed at that meeting. It is not that I am fascinated by my own words; it is only that I consider the basic idea vitally important at this time.

Every Physician Must Lead

The point is that our greatest challenge—our greatest over-all need—is to create an upsurge of leadership by every individual physician in a new crusade for the best possible health for all Americans. This means that all of us—physicians and medical society personnel alike—must give of ourselves . . . personally, intensively, and beyond the call of routine duty or normal schedules.

In these difficult, disturbing times, the individual doctor must be at the core of medical thought, action and progress. His participation, self-expression and initiative are essential if the medical profession is to maintain its rightful

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leadership in solving our nation's health and medical problems.

This era of rapid scientific progress, increasing population, socio-economic changes and political upheavals demands our personal involvement, our most effective thinking, and our individual willingness to take on greater responsibilities.

The American Medical Association today offers a wealth of opportunities for all those who can and will lead on all levels—national, state and local. The ideas are there, the programs are there, and plenty of help is available from AMA and state and county medical societies. We are striving for the highest goals and for the best possible expression of the American medical tradition.

The objectives and the quality will be achieved, however, only through the concern and awareness of the membership itself. If we are lukewarm or mediocre in our efforts, then the AMA will reflect it. But if all of us strive for excellence in every aspect of medical affairs, then the AMA will move closer toward the goals of professional perfection and the best possible medical care and health service for the public.

Too Many on the Sidelines

Unfortunately, too many physicians stay on the sidelines and don't want to get involved in organizational activities, community affairs or public issues. Also unfortunately, they usually are the ones who complain quickest and most frequently about medical leadership when things are not sailing smoothly. It would be far wiser and much more constructive if they took part in medical affairs and expressed their views on policies which they dislike, or which they think should be modified. With a little effort, they might find the minority gradually becoming the majority. No physician should surrender his voice through apathy.

The greatest asset of the AMA, or a state or county medical society, is the individual doctor who is concerned, who is alert to the needs and issues of the day, and who gives some of himself to organized medicine's activities.

Therefore, we must work hard for the fullest possible membership and participation. More than ever before, it is essential that the AMA clearly and undeniably represent the best thinking of the vast majority of American physicians.

In case I am sounding too much like a preach-

er at this point, let me offer you a bit of relief by quoting a little item from the *Industrial News Review*—reprinted in a recent issue of *The AMA News*. It said:

"The only exercise some people get is jumping to conclusions, running down friends, sidestepping responsibility, and pushing their luck."

That verbal castigation, taken in its entirety, would not apply to most physicians. They are too busy curing illness and saving lives to qualify for such an unflattering description. Nevertheless, keeping in mind the legislative and political struggle which lies ahead of the medical profession, we might apply it to our thinking about the physician's obligations over and above the daily practice of medicine.

—I hope, for example, that no physician will jump to conclusions about the outcome of our fight against Social Security health care—either on the side of defeatism or the side of complacency.

—I hope that every physician, instead of running down his medical leadership, will offer vigorous cooperation and constructive advice.

—I hope that all physicians will accept a large measure of personal responsibility, not just in the campaign against the King-Anderson type of legislation, but also in positive imaginative efforts to solve the kind of problems which give rise to such political issues.

—And I hope that no physician will relax under the delusion that we can continue to push our luck—in a vague belief that the stress of the international situation, or backstage political maneuvers, or a change in the nation's political complexion will somehow cause these pesky issues to fade away from our doorstep.

They will not. The problems of how to finance health care—not just for the aged but for our entire population—will remain until they are solved in a manner satisfactory to the vast majority of the American people. If we in medicine do not exert leadership in developing and *improving* existing, voluntary mechanisms, then the people will turn to politicians and the panacea of federal legislation.

Therefore, our *first* task—our most *urgent* task in point of time—is to keep the door open so that we may continue our leadership, and so that we may preserve the full opportunity to improve existing mechanisms. If we fail to face up to this immediate task, we soon shall find ourselves confronted by a partially closed

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door. And there will be considerable political and ideological weight on the other side, trying constantly to narrow the opening and shrink our field of opportunity.

So, if we are to keep that door open for the constructive effort of which we are capable, we must have not only alertness and participation by physicians and medical organizations; we also must have the highest possible degree of unity within the entire profession.

I want to emphasize just one point—for Indiana doctors and all American doctors. Let's not forget that *all* of us are physicians first . . . doctors of medicine . . . members of the medical profession. We all had the same basic medical education and training—to prepare us for serving humanity.

The extra toga which some of us have donned—whether as surgeons, pathologists, pediatricians, cardiologists or what have you—simply denotes an additional refinement of our medical interests and efforts.

Regardless of our field of practice—general or specialized—most of us belong to medical and scientific organizations which are concerned with our particular interests. This is right and proper, and it makes for better medicine all along the line.

Unity Only Through AMA

However, the fact remains that there is only one organization which represents all of us, acts for all of us, and serves all of us—and that is the American Medical Association. If we are to achieve medical unity, it can be accomplished only by mobilizing all doctors under the banner of the AMA, which is dedicated to the interests of the entire medical profession and all the American people.

As you know, the administration in Washington, organized labor and their allies are planning an all-out drive for enactment of the King-Anderson legislation next year. We in medicine will have to make a tremendous effort to rally strong, overwhelming professional and public support for our position. This, of course, is the urgent task to which I have referred earlier.

But health care for the aged—although an extremely important, timely subject—is actually only one of the many difficult issues which medicine will be facing in the times ahead.

All of them—if we are to be effective and successful—will require medical unity. The time has passed when we can afford to think, act and speak as a myriad of splinter groups—as specialists, general practitioners, solo or group practice men, medical teachers, researchers, public health officials, or any other category you might name.

The medical profession—demonstrating a real dedication to the best ethics and traditions of medicine—must organize a united front.

Building an Image

Much is heard these days about so-called "images." We must build a public image of the physician and the profession as men and women who are interested in the welfare of their patients and the public at large.

This public image, however, will mean nothing if it is simply based on publicity-gimmicks or the slickness of the so-called Madison Avenue technic. It cannot stray too far from the realities of modern-day medicine.

It can and must be based upon sincerity of purpose, professional excellence, positive policies, and a concern for public welfare—the latter demonstrated not just by words but by practical, workable programs.

Personally, I think we can do a pretty good job of building a good public image—if we will recognize and carry out *fully* our obligations as members of a profession dedicated to the service of the people.

So far, I have stressed the need for participation, leadership and unity in our efforts to solve health problems and defeat misguided political proposals involving health care. Let me take my point one step farther, and let me make one more demand on your sense of duty.

Citizens as well as Doctors

If we show activity and awareness only when a public or political issue involves medical care, then we are vulnerable to the accusation that we are acting only in self-interest.

On the other hand, if we demonstrate a constant, continuing concern for community affairs and political questions, then I believe that the public will more readily listen to us when we express our opinions on the health and medical issues.

It all boils down to a point you have heard many times before—but it still is a point on which too few doctors have taken personal action. And that is the simple fact that we, as

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citizens and Americans, have the responsibility and duty to take part in the political life of our community, our state and our nation.

In the short time that remains, I would not presume to be enough of an orator to convince you with my own words. Therefore, let me give you three brief, pertinent quotations from three very famous Americans who were pioneers in the development of this democracy which all of us treasure.

Thomas Paine, one of the architects of the American Revolution, pointed out:

"Those who expect to reap the blessing of freedom must, like men, undergo the fatigues of supporting it."

William Penn, another great early American, once remarked that "governments go by the motion men give them."

And George Washington said:

"Government is like fire—a dangerous servant and a fearful master."

Those ideas, with countless variations, have been echoed and repeated down through the years by all who believe in our democratic way of life. What they have been saying is this: politics is not an activity that should be entrusted to the venal or the second-rate; it is everyone's responsibility—including physicians.

Participation in Government

Here in this state, you have made a great start toward putting those ideas in action through the Indiana Health Organization For Political Education. I want to congratulate you on the work you are doing and on the community meetings which I-HOPE has held or scheduled in Fort Wayne, South Bend, Indianapolis and Evansville.

Now, on the national level, the medical profession has launched a new, bipartisan project to assist physicians in organizing for effective participation in political and government affairs.

Known as the American Medical Political Action Committee, it is headed by Dr. Gunnar Gundersen of LaCrosse, Wisconsin. One of the board members is your own Dr. Donald E. Wood of Indianapolis. AMPAC will function independently of the AMA, and it has its own separate headquarters in Chicago.

Stated very briefly, the purposes of AMPAC are: to promote the improvement of government by encouraging physicians to take a more active part in public affairs; to educate physicians and others on the nature of government, on important political issues, and on the records and positions of political parties, officeholders and candidates for office, and to assist physicians in organizing themselves for more effective political and civic action.

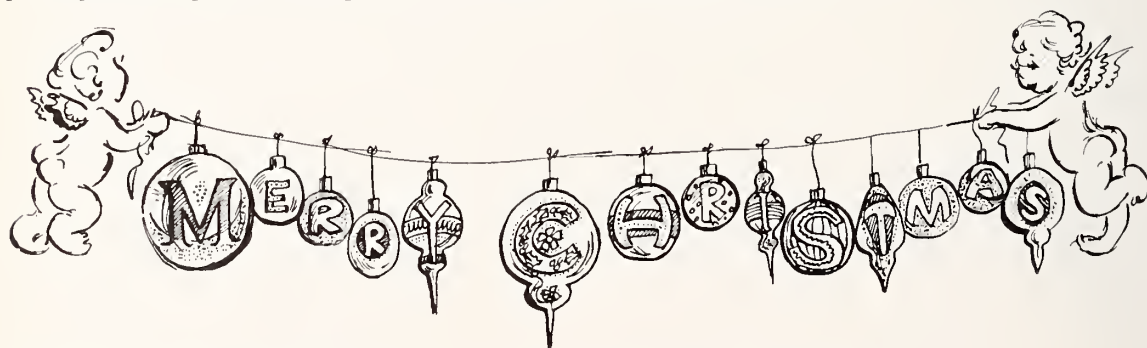
I hope that you here in Indiana, as individual citizens and through I-HOPE, will give maximum cooperation and support to the new national committee, which is late in getting into the field.

Most of us, I know, would much rather concentrate on good medicine, and leave politics to the other fellow. However, we no longer can ignore the fact that the future of medical practice in this country will be determined by the attitudes and actions of politicians.

Dr. Homer Humiston put it this way in his recent president's address to the Washington State Medical Association:

"As physicians, I believe we have the same duty to patients to protect them from inferior political medicine as we have to protect them from phony cancer cures. If we have the duty, we have to be effective where the issue is joined, namely in the political arena. . . . We should face up to the realities of the political arena, and these realities are pretty rugged."

I agree, and I say to you that the unity and success of the medical profession in 1962 will depend upon the courage and effort of you—the individual physician. ◀



DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Florida Licensing Statute for Psychologists Unconstitutional—The Florida statute which prohibits anyone from practicing as a psychologist without a certificate is unconstitutional, according to the Florida Supreme Court. In granting the Florida State Board of Examiners of Psychology unlimited authority to determine the scope of examination required and the educational prerequisites for the issuance of a certificate unlawfully delegated legislative functions to the Board.—*Husband v. Cassel*, 130 So. 2d 69 (Fla., May 5, 1961).

Technicality Doesn't Bar Revocation of Physician's License in New York—The fact that a vacancy exists on the Committee on Grievances, because of the death of one of its members, does not invalidate the revocation of a physician's license in New York. An intermediate appellate court confirmed action taken by the Board of Regents, on recommendation of the Committee on Grievances, to revoke the license of a physician for submitting false medical reports and false bills to an attorney to assist him in making false claims for personal injuries.

The New York law provides that the Committee on Grievances shall consist of ten members, and it requires a unanimous vote of the Committee to find a practitioner guilty. It also provides, however, that a quorum of the Committee shall consist of six members. The court held that the unanimous vote of a committee consisting of more than a legal quorum is a unanimous decision. Accordingly, the unanimous vote of the nine remaining members of the Committee was sufficient to sustain the revocation of the physician's license.—*Wasser-*

man v. Board of Regents of the University of the State of New York, 212 N.Y.S. 2d 884 (N.Y., March 21, 1961). (Editor's Note: The circumstances surrounding the revocation of Dr. Wasserman's license were similar to those in *Application of Shaw*, 212 N.Y.S. 2d 701, reported in *The Citation*, Vol. 3, No. 10, p. 59.)

Surgeon and Anesthesiologist Liable for Negligent Administration of Anesthesia—The Supreme Court of Pennsylvania has affirmed a \$75,000 judgment against a surgeon and an anesthesiologist. This award was given to a patient who lost his left arm as a result of the negligent administration of anesthesia.

The plaintiff had a bursa condition in his right elbow. The surgeon recommended surgery for removal of the bursa. The patient either suggested or requested that the surgery be performed with a local anesthesia. But due to the nature of the surgery, the surgeon advised a general anesthesia. The surgeon had the patient admitted to the Graduate Hospital in Philadelphia.

On the day following his admission the patient was taken to the induction room for the administration of anesthesia prior to the operation. The anesthesia was to be performed by personnel of the anesthesiology department, all of whom were employees of the hospital. The defendant anesthesiologist was the chief of the department and employed and paid by the hospital. The defendant surgeon had ordered a general anesthesia. He did not specifically instruct the anesthesiologist as to the nature of the general anesthesia.

In the induction room the patient was pre-

AT LAW

Continued

pared for an injection of sodium pentothal to be followed by a general anesthesia of cyclopropane gas, ether and oxygen. The initial preparation was by a registered nurse doing graduate work in anesthesiology who was employed and paid by the hospital. When the patient was prepared for the injection of sodium pentothal the registered nurse notified the defendant anesthesiologist. The anesthesiologist was busy at the time. He directed a resident physician, a hospital employee in the anesthesiology department, to administer sodium pentothal.

The resident anesthesiologist injected the needle in the patient's left arm and was proceeding with the sodium pentothal injection when the patient instantly cried out with pain in his left forearm and hand. The resident then either removed the needle or it slipped out. He summoned the defendant anesthesiologist. When the defendant anesthesiologist arrived the patient although under the effects of the sodium pentothal could be aroused. The patient's left arm was then blanched and he had very little pulse.

After some deliberation the defendant anesthesiologist and the resident together with the registered nurse proceeded to administer the general anesthesia.

The patient was then removed to the operating room for the surgery of his right arm. The defendant surgeon was not told by the defendant anesthesiologist or anyone else of what had taken place in the induction room. The surgery on the right arm was successful. It was concluded within thirty to thirty-five minutes.

The defendant surgeon left the hospital without visiting the plaintiff in the recovery room. About two hours after the sodium pentothal injection, the defendant surgeon learned of the incident which had taken place in the induction room. He returned to the hospital when the plaintiff's condition worsened.

Numerous measures were taken by the defendant anesthesiologist, the surgeon and others to counteract the effects of the sodium pentothal in the patient's left arm. But such efforts were of no avail. Three days later the plaintiff's left arm had to be amputated.

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vasation of the sodium pentothal had been made. In either situation, it was evident that the injection had caused an arterial spasm.

The court found that the resident anesthesiologist was clearly negligent in this case. Furthermore the court held that the resident anesthesiologist had acted as the defendant anesthesiologist's agent and therefore the defendant anesthesiologist was also clearly responsible for this injury.

The court also held that the defendant surgeon was liable upon the basis of his own negligence and of his responsibility as principle for the defendant anesthesiologist's negligence. Among the many facts which the court pointed out in connection with its opinion were: the defendant surgeon could and did see that the plaintiff's left arm was extended on the intravenous board when the patient entered the operating room; the defendant surgeon assumed that when the patient was presented to him in the operating room that he was ready for surgery; the defendant surgeon made no inquiry about the plaintiff's reaction to the anesthesia, although the defendant anesthesiologist and his assistants

did the unusual thing of remaining in the operating room and watching the left arm; the plaintiff's arm visibly deteriorated during the operation and the pulse vanished while in the recovery room afterwards; and the defendant surgeon left the operating room and the hospital without seeing the plaintiff in the recovery room.

The court stated: "There is no dispute that the misuse of sodium pentothal caused the condition of the plaintiff's arm, which in turn caused its amputation. The jury needed no expert testimony of what [the defendant surgeon's] duty was: it was, so far as they were concerned, to do something quickly for a dangerous condition which the evidence shows was visible and urgent. Something was done, though too late. . . ."

The defendant surgeon testified during the trial that he was "the boss of the surgical end of it." The defendant anesthesiologist testified that the defendant surgeon had the authority to ask or tell him what sort of anesthesia he wanted, although it was not the practice at the Graduate Hospital to do so. The defendant surgeon said that if it was best for his patient's safety he would discontinue the operation and tell the



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increases local blood supply and oxygen where needed most . . . to relieve distressed "walking" muscles . . . for sustained, gratifying relief of pain, ache, spasm, intermittent claudication.

Indicated in:

arteriosclerosis obliterans

diabetic atheromatosis

ischemic ulcers

thrombophlebitis

thromboangiitis obliterans

night leg cramps

Raynaud's syndrome

cold feet, legs and hands

CAUTION: Like any effective peripheral vasodilator, Arlidin should be used with caution in the presence of recent myocardial lesions, severe angina pectoris and thyrotoxicosis. There are no known contraindications to its use. Complete detailed literature available to physicians.

AT LAW

Continued

anesthesiologist to stop giving the anesthetic, particularly in a minor elective surgical procedure. The court held that upon the basis of the evidence the defendant anesthesiologist was the agent of the defendant surgeon. Accordingly the court, citing *Yorston v. Pennell*, held that under the doctrine of respondeat superior the defendant surgeon was responsible for the defendant anesthesiologist's negligence.

A dissenting opinion was filed. In this opinion it is stated: "There is not a scintilla of evidence of any direct negligence on [the defendant surgeon's] part sufficient to subject him to liability. On the other hand, neither [the defendant anesthesiologist] nor [the resident anesthesiologist], nor the [registered nurse] were acting in an agency capacity for the [defendant surgeon] at the time of the injection of the sodium pentothal."—*Rockwell v. Stone*, 173 A. 2d 48 and 173 A. 2d 54, (Pa., July 18, 1961).

Judgment for Injuries from Tetanus Antitoxin Upheld—The Kansas Supreme Court has upheld an award of \$79,161 to a woman, 37, who

had a reaction to a tetanus antitoxin shot she received in a hospital. The plaintiff alleged that the TAT shot had been administered by a hospital intern without waiting the necessary time after a skin test by a nurse to determine her sensitivity to the serum. The plaintiff claimed that as a result of the subsequent serum sickness she sustained a hearing loss of from fifty to fifty-five percent and underwent a noticeable personality change. Prior to the incident the plaintiff had been a PBX operator and earned \$75 a week. At the time of the trial she was working in a toy factory at \$40 a week.

There was conflicting testimony on the value of the skin test in predicting delayed reactions to the serum and a conflict among the witnesses in regard to the period of elapse time between the skin test and the injection of the tetanus antitoxin.

The court ruled that "on the record before us we cannot say the amount of the verdict is such as to shock the conscience of the court and we therefore hold the verdict was not excessive."—*Necley v. St. Francis Hospital and School of Nursing, Inc.*, 363 P.2d 438 (Kan., July 8, 1961). ◀

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

February 27, 28, March 1 and 2, 1962

Palmer House, Chicago

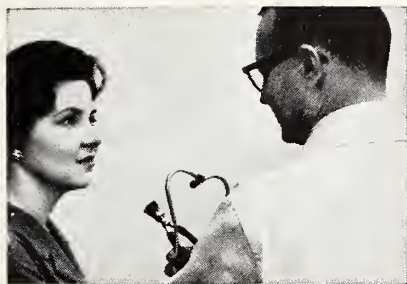
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Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

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SUCCESSFUL FAMILY PLANNING...BASED ON YOUR COUNSEL AND **LANESTA® GEL**

The new baby is beautiful, but his arrival raises some problems in family planning on which the mother will need help — *your* help. What you counsel or suggest to her may determine the family's happiness for many years to come. When she comes in to see you for her routine postnatal check-up, you have an ideal opportunity to counsel her and answer her questions. It's also an ideal time to recommend the use of Lanesta Gel.

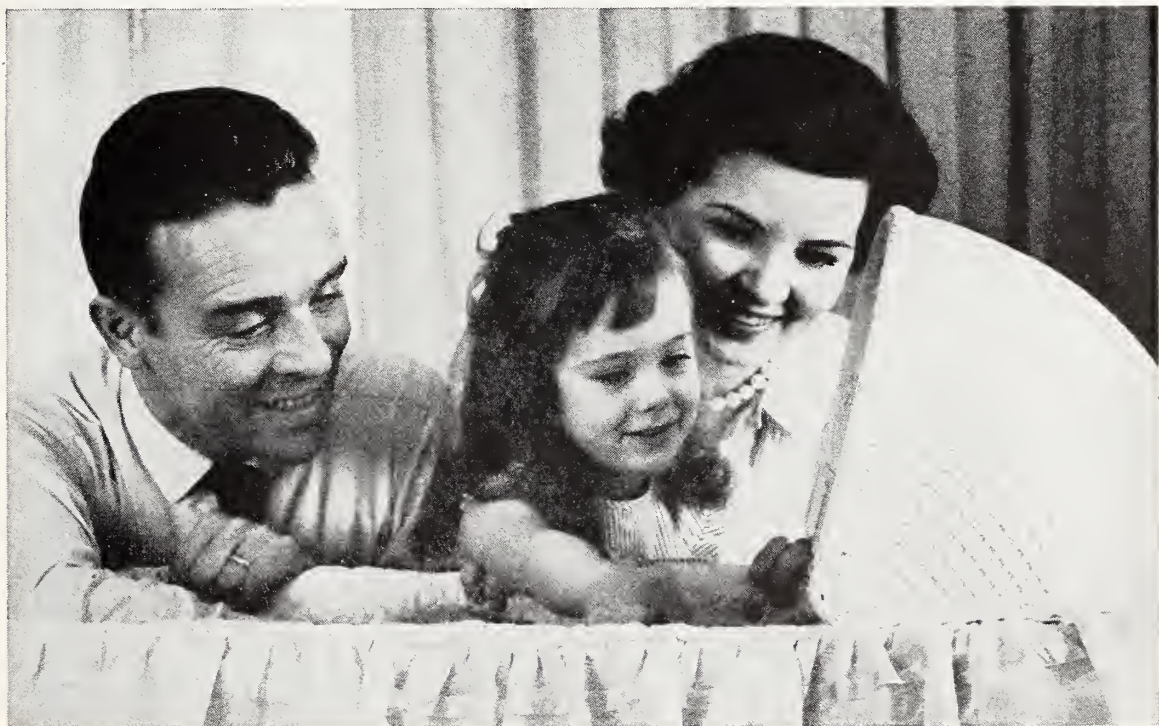
Lanesta Gel, with or without a diaphragm, is a most effective means of conception control. Lanesta Gel offers faster spermicidal action because it rapidly diffuses into the seminal clot. In fact, the mean diffusion spermicidal time of Lanesta Gel is three to seven times faster than the mean diffusion times of ten leading commercially available contraceptive creams, gels, or jellies, according to Gamble ("Spermicidal Times of Commercial Contraceptive Materials — 1959").*

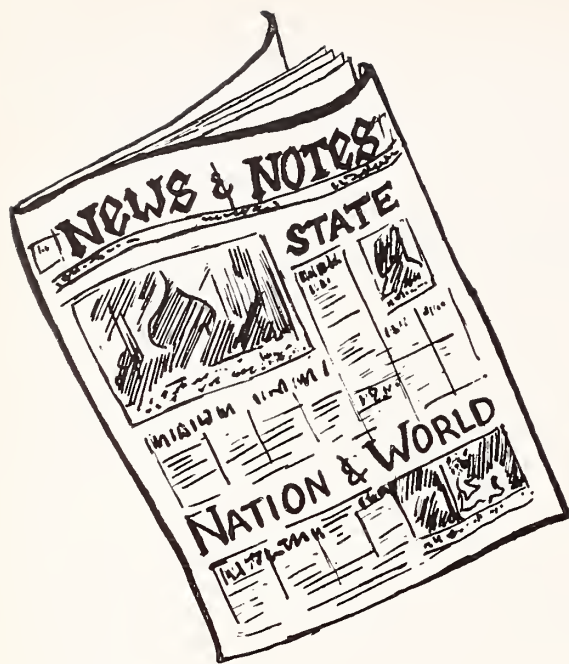
Lanesta Gel has complete esthetic acceptance and is well tolerated.

*Gamble, C.J.: *Am. Pract. & Digest. Treat.* 11:852 (Oct.) 1960. See also Berberian, D.A., and Slichter, R.G.: *J.A.M.A.* 168:2257 (Dec. 27) 1958; Kaufman, S.A.: *Obst. and Gynec.* 15:401 (March) 1960; Warner, M.P.: *J.Am.M. Women's A.* 14:412 (May) 1959.

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Dr. Guy Owsley to Head I-HOPE; Political Workshops Planned

New chairman of the Indiana Health Organization for Political Education is Dr. Guy A. Owsley of Hartford City who was elected to the post by the I-HOPE Board of Directors at the annual meeting October 25.

Other officers named include: Dr. Kenneth L. Olson, South Bend, first vice-chairman; Dr. E. T. Edwards, Vincennes, second vice-chairman; Dr. Don E. Wood, Indianapolis, secretary.

Dr. Owsley, in subsequent action, re-appointed Dr. Joseph M. Black, of Seymour, as treasurer.

In his annual report, Dr. Olson, immediate past chairman, reported that Indiana physicians contributing to I-HOPE have subscribed an average gift of more than \$43.00.

Dr. Olson said: "I-HOPE plans a series of political workshops throughout Indiana; it plans to disseminate pertinent information from time to time; it plans vigorous support of 'get-out-the-vote' programs; it plans to come actively to the aid of candidates of both parties who are

pledged to dedicate their efforts to reversing the socialistic trend in this country."

He pointed out that I-HOPE can accomplish its program only by the all-out financial and moral support of physicians and others who are similarly dedicated.

"The support of every doctor is urged—and drastically needed, because the battle will be joined as never before in the 1962 elections."

I-HOPE, which has no association whatever with the state or county medical societies, was organized in late 1960 and made its weight felt in the elections of that year, actively supporting candidates who were pledged to preservation of the free enterprise system.

I-HOPE leaders point to the fact that three successful congressional candidates, of their own volition, stated that they would have been defeated had it not been for the support of I-HOPE.

All three, by their votes and their public statements have carried out their pledge to work against the socialistic trend.

Maj. Gen. Hartford Appointed Executive Director of Military Surgeons

Dr. Leroy Burney, president of the Association of Military Surgeons, has announced that Major General Thomas J. Hartford, recently Deputy Surgeon General of the Army, and now retired, will serve as Executive Director of the Association. Colonel Robert E. Bitner who has been in charge of the director's office in addition to serving as editor of the association will, in the future, devote all his time to editing the association's official journal *Military Medicine*.

PART II OB-GYN BOARD EXAMS SET FOR APRIL 9-14, 1962

The next scheduled examinations (Part II), oral and clinical, for all candidates, will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from April 9th through 14th, 1962. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates participating in the Part I Examination will be notified of their eligibility for the Part II Examinations as soon as possible.

Current Bulletins of the American Board of Obstetrics and Gynecology outlining the requirements for application, may be obtained by writing to the Secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6.

Johnson & Johnson Grant Supports Film on Staph Infections

A new 16mm color film on the problem of staphylococcus infection in hospital nurseries is now available to medical and nursing organizations. The 30-minute film was produced by the American Academy of Pediatrics under a grant from Johnson & Johnson. Prints of the film may be obtained by contacting any Johnson & Johnson sales representative or by writing Johnson & Johnson Hospital Division, New Brunswick, N. J. Two other films, previously issued, are available—"Hospital Sepsis—A Communicable Disease" and "I Dress the Wound". The three films are designed to aid in the diagnosis, control and treatment of sepsis in hospitals.

Dr. Mell B. Welborn, Evansville, has been elected to the Board of Governors of the American College of Surgeons, according to a recent announcement.

Indiana Assistants Attend National Meeting at Reno


Mrs. Bettye J. Fisher, Evansville, presided during the October meeting of the American Association of Medical Assistants at Reno, Nev.

Twenty-seven members of the Indiana State Association of Medical Assistants were among those attending the national meeting. They included the Indiana Delegates, Mesdames Ernest Wells, Evansville; Gregg Appleby, Richmond; and Glenn Montgomery, Shelbyville. Dr. Robert Royster, Evansville, is an advisor of A.A.M.A.

AMA President Dr. Leonard W. Larson was keynote speaker for the convention.

Dr. Beeler Named Roentgen President

Members of the Indiana Roentgen Society have elected Dr. John W. Beeler president for the current year. Assisting him are Drs. Jack W. Loudermilk, vice president and David E. Wheeler, secretary-treasurer.



**PROTECTION AGAINST LOSS OF INCOME
FROM ACCIDENT & SICKNESS AS WELL AS
HOSPITAL EXPENSE BENEFITS FOR YOU
AND ALL YOUR ELIGIBLE DEPENDENTS**

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**PHYSICIANS CASUALTY & HEALTH
ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902**

Handsome Professional Appointment
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New Medico-Environs Offers Attractive Adjunct to Hospital Facilities

MEDICO-ENVIRONS is a long-needed adjunct to existing hospital facilities in Indianapolis. As its name implies, it is a medical environment designed and equipped to care for the chronically ill and the longterm patient. To this end, the new building, now ready for occupancy, has a total of 112 beds. The second floor comprising 64 beds is designed for the care of bedridden patients, although it does have a lounge, with sliding glass doors leading to a terrace for patients able to be up for short periods.

The first floor is planned to accommodate ambulatory patients, able to care for themselves whilst still requiring medical supervision. The rooms, furnished in attractive colors, are far removed in appearance from the usual hospital decor. There is a large lounge on this floor with doors leading to a terrace and patio; and even a small, well equipped kitchen for the patients'

use, should they wish to make their own coffee or even indulge in some cookie or cake baking. Emphasis in this section of the hospital is directed toward assuring the patients an environment and atmosphere as close as possible to their own home.

Medico-Environs occupies a site of 11 acres, and it is hoped, eventually, to build some efficiency and one bedroom apartments for the use of aged patients still able to retain their independence whilst providing them with the reassurance of the close proximity of medical care when necessary, and the companionship and convenience of the recreational and dining room facilities located in the main building.

The patient will be attended by his own personal physician, and the hospital is fully equipped with laboratory, x-ray, physical therapy and examining rooms. There is a staff of registered nurses, therapists, and dietitians.

This newest facility will help to bridge the gap between the hospital and the home for the chronically ill patient, thereby making available more desperately needed beds in the large hospitals for the acutely ill patients.

Full details may be obtained from Miss Gladys Post, Administrator, Medico-Environs, 3350 Carson Avenue, Indianapolis 27.

The Norbury Hospital

**Established 1901 — Incorporated
Licensed — Jacksonville, Illinois**

FRANK GARM NORBURY, A.M., M.D., Medical Director

HENRY A. DOLLEA, M.D., Superintendent

FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Blue Cross-Blue Shield Official Appointed to U.S. Advisory Committee

Mr. Harry Hineman, Actuarial Division Director for Indiana Blue Cross-Blue Shield, with six others, has been appointed to a three-year term on the Surgeon General's Advisory Committee on the U. S. National Health Survey. The National Health Survey was established by Congress in 1956 as a continuing program to determine the amount and kind of illness in the population and to gather information on related health topics such as disability, accidental injuries and hospitalization. The Advisory Committee reviews plans and progress of the Survey and assists in formulating principles and methods of cooperation with private and public organizations.

Deaths

Clifford E. Cox, M.D.

Dr. Clifford Earl Cox, 72, general practitioner and surgeon for nearly 50 years in Indianapolis, passed away Oct. 14.

Dr. Cox had practiced medicine in Indianapolis since graduation from Indiana University School of Medicine in 1912.

He was active in lodge and organization work, having been a potentate of the Murat Shrine in 1953-56, and serving as treasurer from 1936 to 1960.

Hardin S. Dome, M.D.

Dr. Hardin S. Dome, retired Evansville area general practitioner, passed away Oct. 17. He had maintained a practice in southern Indiana for 60 years.

Dr. Dome had been in semiretirement since leaving Evansville in 1939, at which time he moved to Tell City.

Dr. Dome began his practice in Eureka, Ind., in 1900, after graduation from Kentucky School of Medicine, now the Louisville School of Medicine. He served as president of the Perry County Hospital Board in 1950.

Virgil G. Hursey, M.D.

Dr. Virgil G. Hursey, 71, who practiced at Milford, Ind., the past 33 years, passed away suddenly Oct. 19.

Dr. Hursey had practiced at Ligonier and Cromwell before moving to Milford in 1928. He was a graduate of the Chicago College of Medicine and Surgery, Class of 1913.

Robert C. Luckey, M.D.

Dr. Robert C. Luckey, 59, of Wolf Lake, passed away Oct. 6 at his home. He was a founder of the former Luckey hospital at Wolf Lake.

At the time of death, Dr. Luckey was retired from active practice as an abdominal surgeon. He was a graduate of the I.U. School of Medicine in 1927, and also studied at the University of Vienna.

E. Bishop Mumford, M.D.

Dr. E. Bishop Mumford, well-known Indianapolis orthopedic surgeon and founder of the Indianapolis Industrial Clinic, passed away Oct.

23 at the age of 82. He had lived in Indianapolis for 50 years.

During the past year, the orthopedic clinic at Marion County General Hospital was named in his honor. Dr. Mumford was a founder and past-president of the American College of Orthopedic Surgeons and the Indiana Bone and Joint Club.

A graduate of Johns Hopkins, Class of 1905, Dr. Mumford was a Army Medical Corps Captain during World War I; he was a former member of the Board of Health in Indianapolis and a former associate in surgery at the I.U. School of Medicine.

Kenneth D. Sneary, M.D.

Dr. Kenneth D. Sneary, 67, well-known Avilla, Ind., physician, passed away Oct. 16.

A veteran of World War I, Dr. Sneary began practice in Avilla in 1933. He was a graduate of the Ohio State University School of Medicine, and on the staffs of McCray Memorial Hospital, Kendallville, and Soldiers Hospital, Auburn.

REVOLUTIONARY PROSTHESIS



Improves gait • Increases Comfort

Available from HANGER is the increasingly popular below-knee Patellar-Tendon Bearing (PTB) Prosthesis, developed at the University of California, Berkeley, with the cooperation of members of the AOPA, representatives of prosthetics schools, and the V.A. Prosthetics Center.

The PTB advantages to the wearer are: (1) It improves the gait. (2) It increases the comfort. (3) It reduces fatigue. (4) It improves the appearance.

HANGER Prosthetists have received special university training on the PTB. This advanced training enables HANGER Prosthetists to work closely with you in the rehabilitation of your amputee patients. May we serve you?

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418 N. Main St., Evansville, Ind.

County News

Decatur

Fourteen members of the Decatur County Medical Society met Sept. 22 to hear Dr. Dale Marvel, of the Merchants National Bank and Trust Co. in Indianapolis, speak on Federal Estate and Gift Taxes.

Dubois

Mr. Robert Parker, Dubois County Civil Defense Director, spoke to 34 members of the Dubois County Medical Society at their October 12 meeting.

Fountain-Warren

Members of the Fountain-Warren Medical Society will host local pharmacists and attorneys and their wives at a fish fry in the near future.

Huntington

Dr. E. J. Berman, Indianapolis, spoke on Clinical Problems in Pediatric Surgery at the Oct. 10 meeting of the Huntington County Medical Society. There were 19 members present.

Lake

Mr. Frank Barton, Secretary to the Council on National Security for the AMA, spoke on civil defense to 110 Lake County doctors and their wives at a county medical society meeting Oct. 11.

Marion

Members of the Marion County Medical Society were co-sponsors of the fifth annual Physicians-Coaches conference, Oct. 26 in Indianapolis.

Dr. A. D. Dennison, Jr., was in charge of the program. Speakers included Drs. James H. Gosman, Thomas Brady, Jack I. Taube, and Karl L. Manders.

Monroe

More than 500 persons were tested at a free glaucoma clinic recently co-sponsored by the Monroe County Medical Society and the Bloomington Lions Club.

Speakers at the society's Oct. 26 meeting were Joseph F. Hesselgrave, district manager, Social Security Administration; Harry Dixon, Supervisor, Indiana Division of Vocational Rehabilitation; and Dr. E. B. Haggard, chief medical consultant for the disability determination section. Twenty-one members attended the program.

Shelby

Dr. V. B. Scott spoke on Heart Sounds at the Oct. 4 meeting of the Shelby County Medical Society.

Presenting a program on polio vaccine at the group's Nov. 1 meeting were Drs. Andrew Offut and Carl Culbertson, Indianapolis.

Tippecanoe

Newly-elected officers of the Tippecanoe County Medical Society are Drs. Harley Frey, president; F. J. Babb, vice-president; and J. J. Onorato, secretary. Delegates to convention are Drs. R. B. Dubois and Babb; Dr. R. W. Vermillya is alternate.

Wells

Dr. Frank R. N. Gurd, Professor of Biochemistry at Indiana University, spoke on "Three Dimensional Structure of Proteins" at the Oct. 16 meeting of the Wells County Medical Society. ◀

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SPECIALIZED EXPERIENCE
IN THE RESTORATIVE
TREATMENT OF
"THE PROBLEM
DRINKER"**

*At The Keeley Institute your patients
are assured of receiving:*

- the most modern, coordinated, comprehensive, rehabilitative regimen
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- full cooperation throughout with the referring physician
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DWIGHT, ILLINOIS**

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1961—The Convention Story





GODSPEED IN '61-'62: Dr. Guy Owsley, Hartford City, presents the president's gavel to Dr. Horry R. Stimson, Gory.



CONVENTION FIRST—The Fireside Conferences dealt with Cordio-Respiratory Disease.

SCIENTIFIC EXHIBITS are a major attraction for convention goers.



DR. GUY OWSLEY welcomes AMA President Dr. Leonard Larson, who was a 1961 keynote speaker.



DR. LARSON joins Senator Homer Capehart, Dr. Guy Owsley and President-Elect Harry R. Stimson at the speaker's rostrum.



THE ANNUAL ART AND HOBBY SHOW featured an outstanding list of exhibits.



AT THE CORNERSTONE-LAYING CEREMONIES for the new ISMA Headquarters Building, members enjoyed an open air luncheon.



TECHNICAL EXHIBITORS spent many busy hours extolling the merits of their displays.



50-YEAR CLUB members compare notes at their annual reception.



AUXILIARY members pictured here at their banquet kept as busy a schedule as doctors.



DRS. STIMSON AND OWSLEY welcome guests at the President's Reception.



THE ANNUAL BANQUET—always a convention highlight.

Convention Election Results:



Dr. Maurice Glock Named President-Elect by House

Dr. Maurice E. Glock, well-known Fort Wayne internist, was elected president-elect of the Indiana State Medical Association at the closing session of the ISMA House of Delegates Meeting Oct. 26.

Dr. Glock has been chairman of the ISMA Council for the past two years and a member of the council a total of seven years. He is a former chairman of the ISMA Commission on Medical Education.

For two years Dr. Glock served as Indiana chairman of the AMA Education Fund Campaign and was a member of the ISMA Liaison Committee with Indiana University School of Medicine.

Also taking office during convention were Drs. Irvin Wilkens and Dr. Charles F. Gillespie, re-elected treasurer and assistant treasurer, respectively. Elected delegates to the AMA were Drs. Walter L. Portteus, Franklin and Jack E. Shields, Brownstown; their alternates are Drs. William B. Challman, Mt. Vernon and John M. Paris, New Albany.

Councilors who will represent their respective districts until 1964 are Drs. John M. Paris, New Albany, third district, new chairman of the council; William R. Tindall, Shelbyville, sixth; Kenneth O. Neumann, Lafayette, ninth; and Milton F. Popp, Ft. Wayne, twelfth.

Results of the various section elections, which took place during the ISMA meeting are as follows:

Section on Radiology: John W. Beeler, Indianapolis, chairman; Jack Loudermilk, Ft. Wayne, vice chairman; David Wheeler, Indianapolis, secretary.

Section on General Practice: Joe Black, Seymour, chairman; E. T. Edwards, Vincennes, vice-chairman; James Crane, Williamsport, secretary.

Section on Public Health and Preventive Medicine: Arnold W. Brockmole, Evansville, chairman; William R. Taylor, Richmond, vice chairman; Kenneth O. Neumann, Lafayette, secretary.

Section on Medicine: George Willison, Evansville, chairman; Lowell Steen, Whiting, vice chairman; Paul Tischer, Indianapolis, secretary.

Section on Surgery: Richard M. Davis, Marion, chairman; William C. von der Leith, Vincennes, vice chairman; James S. Fitzpatrick, Portland, secretary.

Flying Physicians: Edward Miller, Ft. Wayne, chairman; Paul Sparks, Winchester, vice chairman; Dan L. Urschel, Mentone, secretary-treasurer. ◀

THE WINNERS—112th Annual Convention, Indianapolis, Oct. 23-26 . . .

Art and Hobby Show

Class I: Color Photo

- First: Dr. Truman Caylor, Bluffton
Second: Dr. Truman Caylor, Bluffton
Third: Dr. James B. Warriner, Indianapolis

Class II: Black and White Photo

- First: Dr. J. F. Ling, Richmond
Second: Dr. J. F. Ling, Richmond
Third: Dr. J. F. Ling, Richmond

Class III: Oil Painting

- First: Dr. M. C. Topping, Terre Haute
Second: Dr. Thomas H. Conley, Kokomo
Third: Dr. Thomas H. Conley, Kokomo

Class IV: Collection

- First: Dr. Lall G. Montgomery, Muncie (Alice in Wonderland)
Second: Dr. Lall G. Montgomery, Muncie (Doll Collection)
Third: Dr. Lall G. Montgomery, Muncie (Alice in Wonderland)

Class V: Hobby

- First: Dr. Frank Coble, Richmond (orchid arrangement)

- Second: Dr. Philip Holland, Bloomington (old medical instruments)

Class VI: Crafts

- First: Dr. Harry Kitterman, Indianapolis (etched pewter trays and wood turnings)
Second: Dr. Weldell Stover, Booneville (ceramics)
Third: Dr. Frank Coble, Richmond (pottery)

- Special Exhibit:* Dr. Victor Johnson, Evansville (steamboat display)

Skeet Shoot

- First: Dr. Stamper, Anderson
Second: Dr. George Tindall, Indianapolis

Trap Shoot

- First: (tie) Drs. Claude M. Donahue, Carmel and Charles E. Bush, Kirklin

Golf Tournament

(47 players)

- Low Gross: Dr. Boyd Burkhart, 72
2nd Low Gross: Dr. Joseph Karlick, 74
3rd Low Gross: Dr. Edwin, 75

Scientific Award Winners—1961

3 plaques awarded:

- 1st Award: Philip B. Reed, M.D., and
Vincent B. Alig, M.D., Indianapolis
Exhibit . . . The Use of Tranquilizers, Mood
Elevators and Psychic Energizers
2nd award: Carl B. Sputh, M. D., Indianapolis
Exhibit . . . Nasal Injuries

- 3rd award: Garfield G. Duncan, M.D., Medical
Division, Pennsylvania Hospital, Philadelphia

- Exhibit . . . Progress in the Management of
Essential Hypertension

Honorable Mention

- Charles R. McClave, M.D.
Wm. H. Howard, M.D.
Donald M. Hosier, M.D.
—all of Columbus, Ohio
S. Wm. Simon, M.D., Chief,
Allergy Clinic, VA Center, Dayton, Ohio
William L. Lowrie, M.D., Henry Ford Hospital,
Detroit

For exhibit on:

RESPIRATORY DISTRESS IN THE NEWBORN

TESTS FOR ORAL DRUG UTILIZATION:
SUSTAINED-ACTION TABLETS

THE DIABETIC FOOT—A THERAPEUTIC PROBLEM

Cause and Effect

GUY A. OWSLEY, M.D.

Hartford City

WHEN ONE HAS BEEN privileged to serve an organization such as ours in an executive capacity, he is afforded an opportunity to view a medical panorama which, in detail, is unavailable to the average member. During the past decade each year has added its cause and effect to the mounting problems faced by medicine. But in no year, at least in my experience, has a crystallization of these effects and causes been more apparent than during the year immediately past.

Ordinarily one discusses causes first, but I choose to discuss the effects and in turn follow with the causes.

So that all of us may see for ourselves this accumulation of effects important to our profession and to our social structure generally, I call your attention to four significant pronouncements which have had national and world-wide publicity during the year 1961. After analyzing them let us then examine the causes of these pronouncements—particularly the fallacious application of the causes which have been suggested by those who have been expressing themselves on the subject. For the purposes of this discussion, we clearly accept the premises from which they attempt to reason.

In January of this year was held the White House Conference on Aging. This was the event resulting in the first pronouncement or effect. This so-called non-political monstrosity, delivered by a bureaucratic midwife and spoon-fed by the autocrats of a gagged agenda didn't have a chance to survive infancy excepting as a microcephalic example of mental retardation utterly incapable of presenting the facts. Accused of loading the conference in press accounts planted by the Washington planners, organized

medicine was unduly criticized when the truth is that our voice was silenced as though laryngectomized because, no doubt, of the fear of medicine's viewpoint.

Although not in chronological order, another event occurred just prior to the Governors' meeting in Honolulu. This was a special little White House conference called by the Director of Health, Education and Welfare, with the obvious intention of laying the groundwork for the meeting of the Governors. Forewarned of the necessity for representation at this conference your State Association persuaded our Governor to appoint two representatives from your association to attend this meeting. This action was followed generally throughout the other states. The result was the adoption of an agenda which permitted freedom of speech and, as a consequence, Mr. Ribicoff, at its conclusion, voiced the opinion that the Administration had failed to obtain the evidence it had hoped to use as testimony before the Governors or the Congress. The outcome of this conference demonstrated that when any conference is conducted fairly and when our views are allowed free expression the bureaucrats run for cover.

As a second effect we observe that in February of this year an unprecedented pronouncement was made by the Advisory Body of the National Council of Churches. This organization whose membership comes from almost all of the larger Protestant denominations except the Baptist Church and claiming to speak authoritatively for approximately thirty million protestants, proposed a resolution approving medical care of the aged under social security. Subsequent action, however, by members of the various denominational groups comprising the National

Council did not produce a unanimous stamp of approval for this resolve. This was due no doubt to the "freedom of conscience" principle of protestantism and, although the National Council was conceived to promote unity among major Protestant groups, there are many who would prefer this unity be confined to religious doctrine rather than politico-economic doctrines in which individual groups are singled out for a trip to the wood shed.

Peculiarly and inconsistently, the president of the National Council, who, incidentally, is a Hoosier, addressing himself to an interdenominational group in this city, in May of this year, was reported to have said that the Council favored Federal Aid to Education to be administered *on a local level* but approved medical care for the aged through the Social Security mechanism. How inconsistent is it possible for one to be? The provisions for local level care of the aged is already the law of the land through Kerr-Mills legislation and is deeply imbedded in the political, governmental and social philosophy of our people. But perhaps it is too much to expect that he would be aware of this.

It should be noted in passing that the overwhelming majority of us are indoctrinated in the ideals of the Christian faith, but I doubt that many of us believe that He, the Great Physician, would recommend a patent medicine for the lock-jaw of government intervention if tetanus antitoxin would do a better job.

The third pronouncement of extreme interest to medicine is the Social Encyclical of Pope John XXIII released to the English speaking people in July of this year.

Under Part II Section 2, of this Encyclical titled "Socialization: Origin and Scope," the pronouncement was directed to the thirty-five to forty million Americans as well as Catholics everywhere and offered some startling beliefs most pertinent to the subject and which, with your indulgence, will be quoted out of context. You may be assured that the basic premise will in no way be distorted. I quote—

"Socialization is, at one and the same time an effect and a cause of growing intervention by the public authorities in even the most crucial matters, such as those concerning the care of health, . . . the controlling of professional careers and the methods of care and rehabilitation of those variously handicapped, but it is also the fruit and

expression of a natural tendency, almost irrepresible in human beings—the tendency to join together to obtain objectives which are beyond the capacity and means at the disposal of single individuals."

Continuing, the Encyclical, asks and answers a question. I quote: "Ought it be concluded, that socialization growing in extent and depth, necessarily reduces men to automatons? It is a question which must be answered negatively."

In the final paragraph of the section on socialization the following opinion is pronounced:

"Moreover, we consider necessary that the intermediary bodies and the numerous social enterprises in which above all socialization tends to find its expression and its activity, enjoy an effective autonomy in regard to the public authorities and pursue their own specific interests in loyal collaboration between themselves, subordinately, however, to the demands of the common good."

As stated in the beginning, this quotation is out of context and should be interpreted. In the first paragraph, the assumption is made that it is almost irrepresible for human beings to join together in what amounts to an act of socialism. Further it is stated that when this occurs men do not lose their initiative. Finally in spite of these opinions it is considered necessary that intermediary bodies such as ours should enjoy an effective autonomy in a subordinate capacity.

This proclamation is most important because the Catholic Church is an authoritarian institution and since it tells its members what to believe in matters of faith and morals, there is reason to feel that this pronouncement might be received as a dictum. Additional comment will be made later concerning the application of certain portions of this profound effect.

Through all of the sound and fury of these pronouncements, is it any wonder that the fourth effect should arise from the public authority, more familiar to us as professional politicians, by the proposal of a nostrum with a formula of such quality as the King-Anderson bill? Of course not. In order for the bureaucrat to justify his alleged benevolent social aims it is always necessary to make it appear that he is following the demands of the common good. But to him the common good is usually found only in the pronouncements of vociferous groups, many of unquestioned sincerity in rank and file, but

CAUSE AND EFFECT

Continued

whose mass thinking is done on the authoritarian level of the organization.

A perfect example of this authoritarian level is Mr. Orville Freeman, who occupies cabinet rank as the Secretary of Agriculture. He stated the philosophy of big government in the following way:

"It is pertinent that all government programs for the benefit of the public provide services for the few who do not need them as well as for the great majority who do need them." What specious reasoning, especially when applied to problems of Welfare! I submit that to be more accurate this should read that it is pertinent that all government programs for the benefit of the public provide services for the *many who do not need them* as well as the few who do need them.

Grouping the two White House Conferences as one, I have attempted to document four sources of effects occurring during 1961. The two conferences were conceived to be non-political, albeit with bureaucratic overtones. Second we discover a bureaucratically conceived viewpoint of many of the protestant divisions of the Christian faith. Next, through the social encyclical of Pope John, we find the Catholic version of these effects. Finally we have the pronouncements of those in public authority, with their ears to political expediency, proposing legislation which of necessity must not only be considered political but representative of the program of the present administration.

This brings us to an examination of the causes of these effects. On this point it is virtually impossible to find disagreement among those whose logic and concept of life approves socialization. However distorted their application of those causes may be, as stated before in this discussion, we will accept them enthusiastically as fundamental to the argument justifying our own position.

The number one cause is always given as *Technological progress* and the number two cause as *Demographic change*.

Technological progress by its very nature is the prime reason for the high esteem in which medicine is held. There is no better proof of this esteem than the current suggestion that health care be included as one of the basic social rights along with food, clothing and shelter. If we agreed that medicine has attained this high

esteem isn't it fair to ask—"Whose Technological progress?" The fruits of basic research have always been the result of personal genius, individual effort, unique brains and a will to work and gamble—in the case of the latter, even the will to gamble life itself. Recognizing that basic research has been accumulated in many fields of activity, does any one suggest that the fruits of that labor in other professions and callings, ipso facto are inconsistent with the common good because of the personal reward accruing therefrom? Or because the end product of that attainment may occasionally be tainted by one bad apple in the barrel? If any one has made such a suggestion I haven't heard of it.

Let us look a bit further at the record for an answer to the question "Whose Technological Progress?"

In searching for a major breakthrough in basic research by any personnel under the control and supervision of the Federal Government one outstanding contribution comes to mind—The Sanitation corps of the Army under General Gorgas in the yellow fever expedition. But remember that this was the work of a dedicated man and his dedicated personnel for which all the governmental moneys of the world was not a substitute. While we should gratefully acknowledge any progress, be it by a governmental unit or through private enterprise, this isolated example serves to emphasize two important facts: first, that money under the control of government is the least important ingredient of research, and, second, when one raises the question—"Whose Technological progress?"—the obvious answer is that it belongs to private and personal enterprise.

Illustrations are legion. How much subsidy by big government was received by Louis Pasteur? Or Roentgen? Or Madame Curie? Or Jenner? Or Lister? Or Ehrlich?

Moving on to the 20th Century we find the 19th Century basic research explosively increasing, combined with its application in clinical research, and manifesting itself through the great works of so many. Time will permit mention of but a few. Again let us ask the question—How much government subsidy was received by Harvey Cushing, John B. Murphy, Joslin, Fleming, Wagensteen, Churchill, Blalock, Crile, Lahey, Osler, the Mayo's and a host of others?

Does the historical fact that these individuals have provided the basic research for medicine justify the position that it is all of a sudden

necessary and in fact irrefragable that human beings join together in an act of socialism to obtain that which is assumed to be beyond the capacity and means of individuals to attain? The record disproves this violent assumption and I submit that the surest way to destroy the initiative and independence which has provided this progress is to suffocate it with the deadly fumes of bureaucracy. On this point it is fair to assume that at sometime in the future in a sober attitude of qualitative analysis this fact will stand out—had we allowed the individual to pursue his dedicated course, the plea for crash programs, as advocated by certain modern day researchers, would not have necessitated a \$600,000,000 budget in the department of Health, Education and Welfare as a means to justify its bureaucratic existence.

Confirmation of this assertion is provided in a revelation published in *Medical World News*, issue of August 18, this year. This article reveals the operation of a bricklayer, turned Congressman, Representative John E. Fogarty of Rhode Island, who is credited with being the key force behind the four billion dollar Federal Medicine and research programs. I can best

illustrate the philosophy of this Johnny-come-lately by a quotation from the same periodical: "A lot of people seem to think that if they have a good doctor, they can relax and rely entirely on him to look after their health. Maybe some of their doctors have been a little too inclined to encourage that idea; maybe some of them even believe it themselves. But I say that's a 19th Century idea."

This belief from the man, along with Senator Lister Hill, his counterpart in the Senate, demonstrates conclusively, at least to me, the direction in which we are heading if something isn't done to reverse the activities of these champions of bureaucratic medicine. If those with research aspirations as well as medical educators everywhere are willing to capitulate to big government as the only solution for the continuance of good medical practice, then, I say to you, that if the product is controlled by government the administration of the product will likewise be controlled.

In spite of this apparent trend we accept the number one cause of these effects but we accept it as *ours*, not as that of the bureaucrat who would exploit it for his own gain. But with this acceptance we are obligated to assume a respon-



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CAUSE AND EFFECT

Continued

sibility for the common good, and out of this stems the cold hard fact that we will either use the tools which have been placed in our hands for the purpose for which they are intended or we will face the dictates of the public authority.

This brings us to the second cause—Demographic change. Demography is defined by the American College Dictionary as “the science of vital statistics, as of births, deaths, diseases, population, etc.” But to the socialist this means first, the so-called “population explosion” and secondly the increase in numbers of those reaching three score and ten and beyond.

It is probably facetious to suggest that those who represent medicine have directly contributed more than their fair share to the population explosion. It is reasonable to assume however, that fewer infants expire because of our efforts and no one else's, and we might add that some of our pharmaceutical friends have produced a pill for those countries, notably, Pakistan, who feel the need for fewer people. This in spite of the Senator from Tennessee, who would class them as economic fakers.

Again let us lay claim to a cause which is ours.

At the other end of demographic change, longevity, unequaled in any other country, has been extended by our judicious use of those tools which we have rightly inherited through our own technological progress. But when it's all said and done the bureaucrat now lays claim to those whose lives we have preserved and has the temerity to insist that the poor old folks don't receive adequate medical care.

In reviewing these effects and their causes we have seen how those who are unassociated with medicine would steal our birthright to use in some instances for their own selfish advantage and in others because of misguided thinking. Out of this mire of misinformation comes the realization that the bureaucrat is using every possible means to keep us on the defensive. I propose to you that the time has arrived for counter-attack. Let us tell our story, the story of dedicated individualism, the true history of how we have attained the highest esteem enjoyed by any profession.

To conclude, it is my belief that medicine has neglected for too long the beautiful story of how we have provided the best care obtainable

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at this time or any other time. Let us not be research statisticians to provide a defensive answer to the bureaucrat. Let us expose him for what he is worth, a leech on the public purse, unelected and unrespected, except by the legislator who listens to his cry of despair. ◀

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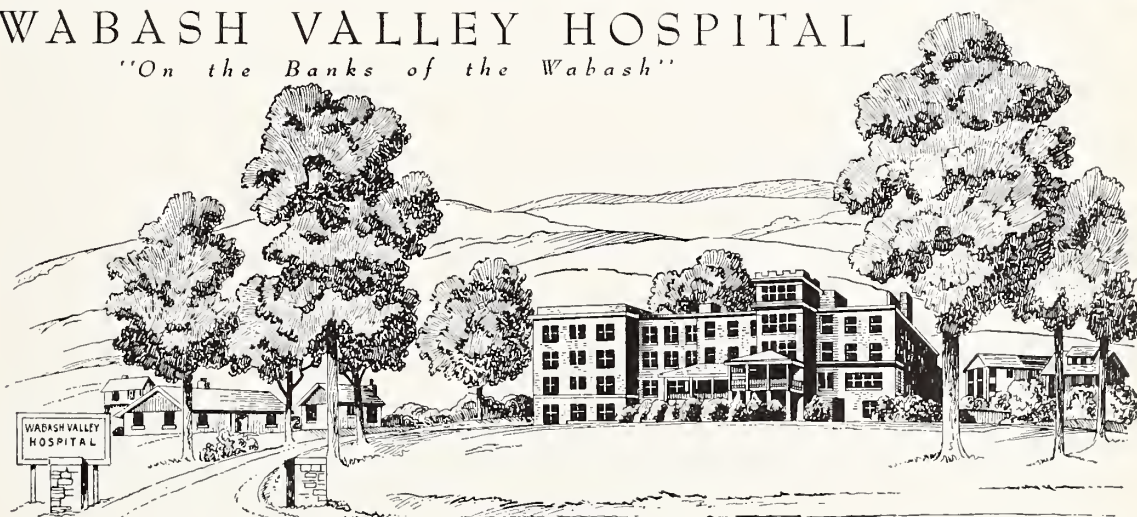
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Address of the President-Elect

HARRY R. STIMSON, M.D.

Gary

For the past year, since this House in session at French Lick saw fit to honor me by electing me your President Elect for 1960-61 and President for 1961-62, I have had the rare privilege of serving under the very able leadership of Dr. Guy Owsley. I would be remiss if I were here to fail to state that I have not only enjoyed this year with Dr. Owsley and the other officers but I have learned much which will certainly be valuable to our organization. So I take time out here to use a much worn salutation but one most fitting: Dr. Owsley, I salute you for a job well done and here and now pledge myself to make the greatest effort to continue your good work and that of our predecessors.

This short talk of mine will in no way conflict with the much broader and more comprehensive address to be delivered by the President, Dr. Owsley, at the annual dinner Wednesday evening of this week, which will involve the overall ideology of the private practice of medicine. I shall mention a few specifics which come closer to home at this time, attempting to suggest on some subjects and to give information on others. To attempt to mention each and every problem confronting the ISMA at this time would be too time consuming and I know there is much work to be accomplished by this body at this session. Therefore I am sure some of you will think of problems which I have thus omitted, but that does not mean that I shall attempt to relegate these problems to a minor spot in the working of the Association this coming year.

First let me mention the House of Delegates itself. I wonder how many of the members here have read the Constitution and Bylaws of the ISMA? It is my opinion that each member of this body should read it, if not each member of the whole state organization. Only in this way will you actually know the duties and responsibilities of the House of Delegates, the Council,

the Executive Committee, the officers, the individual Commissions & Committees and the Executive Secretary. This body, the House, is the legislative body of our Association and actually the real power. The council, Executive Committee and officers carry out or execute the decisions and mandates of the House of Delegates.

Therefore it is most important that each man elected by his local society to this house attend the sessions, also if picked for a Reference Committee he should attend these meetings for this is where some of the most important decisions and recommendations are made, and most important, all members of this body should attend the Reference Committee meetings even though not a member. As you know any member of the State Association can attend these meetings and take part in the discussions and deliberations which come before the Committee. You could do a service by encouraging these men to attend these meetings. If this could be accomplished we would be a long distance on our way of eliminating the criticism which is often heard that "the average member does not have anything to say in the State Association." Also before I leave the subject of the House I would like sometime to have a large enough hall for the House meetings so that more Association members could attend. Of course they would have no word in the deliberations but to have them simply as observers to the deliberations of the House would, I believe, create more general interest in the organization, and the more universal the interest we have of the more than 4000 physicians in the ISMA the stronger the organization will be.

On the legislative portion of our problems I shall pick out only one item which I consider one of the most important. Of course that is HR 4222, the King-Anderson bill or the Social

Security approach to the medical care of the aged. First I must compliment Dr. Don Wood, Chairman of the Commission on Legislation, on the excellent presentation of the testimony which he prepared in the name of the ISMA and which was filed with the Ways and Means Committee during the hearings on the bill in August. Copies of this testimony were provided for the officers, councilors and members of the Legislative Commission and this will be printed in the *Journal** for all of us to read. It is well worth while. The testimony against this piece of legislation was so convincing and overwhelming compared to that testimony for the bill that all of you are aware that the bill is a dead issue for this session. You must note that I say "for this session."

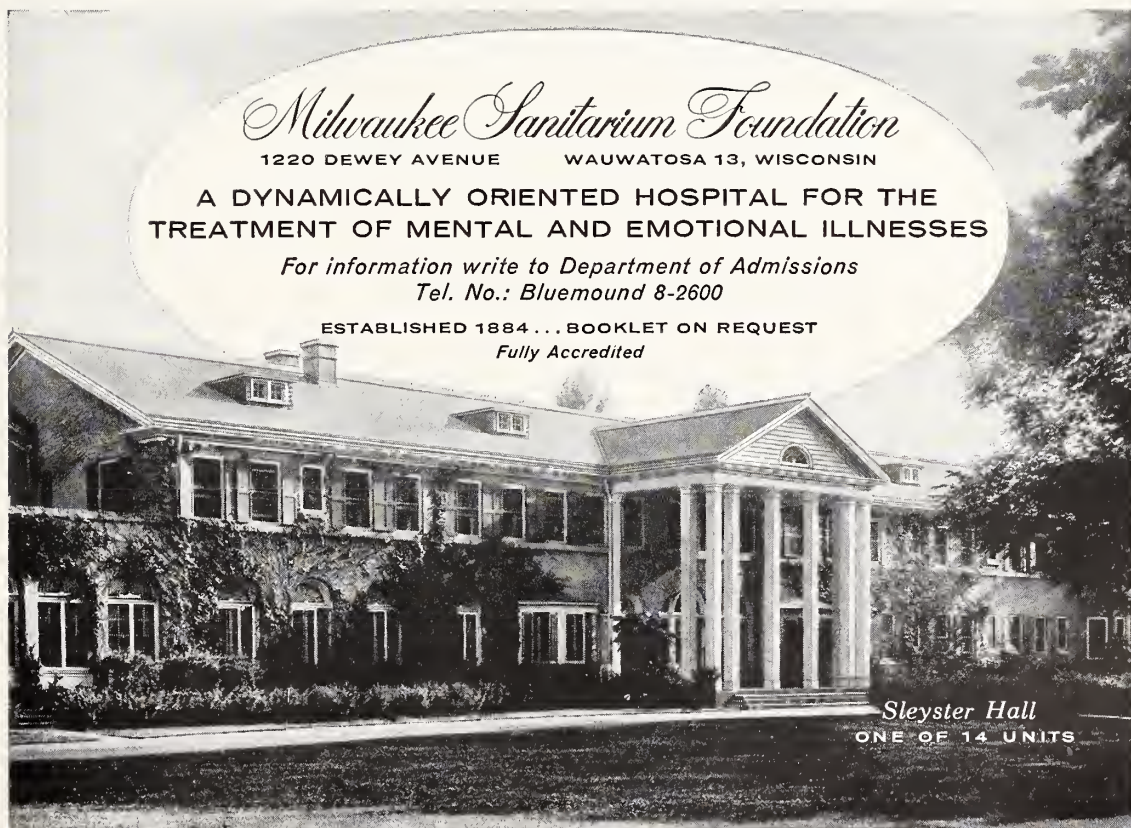
During the latter part of August HEW Secretary Ribicoff told newsmen that there is a strong likelihood that Congress would act next year on HR 4222. Also about the same time an administration congressman talked for an hour on the floor of the House of Representatives urging that HR 4222 be given top priority in 1962.

At a meeting in Chicago in March 1961, called by the AMA and all State Association officers and members of Legislative Commissions, in dis-

cussing legislation such as HR 4222, we were told by Senator Kerr (co-author of the Kerr-Mills Bill) and by Dr. Edward Annis of Miami, Fla. that we could defeat such legislation if we put forward enough effort because we are in the right, but that our efforts must be a continuing process because this type of legislation will be brought up time and again, often under other names and in other dress. So therefore, gentlemen, you see that we have won a BATTLE but the WAR will continue that is yet to be won.

One of our greatest dangers in facing the above and any other outside elements to our system of free enterprise is the fragmentation of medical unity by self-imposed division into splintered self centered groups. I believe ALL Doctors of Medicine believe in private enterprise and the preservation of the private practice of medicine. If I am right all physicians face the same major overall problems and we must face them with a common front. If we can accomplish this one thing I believe a major step will have been taken in our fight to preserve free enterprise in medicine.

There are many more problems facing medicine today and a perusal of some of the Com-



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PRESIDENT-ELECT

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mittee and Commissions and their subject matter of our State Organization will give you some idea of the scope of the problems we face. When a problem arises we can never stick our heads in the sand and sing out that there is no problem. Take the problem of the medical care of the aged for instance, instead of simply stating that there was no problem, your state Association just about one year ago created the Commission for the Aged, and this Commission has become one of the most active we have since its creation.

Also there is the problem of prepaid medical care. Your Commission on Medical Economics and Insurance has been most active and is continually working on these problems. In passing let me say that I believe all doctors should cooperate as nearly as possible with this conception of paying for a large part of the medical costs for without these plans we would be much more of a "sitting duck" for some type of governmental medicine. Although we have our differences at times with the "Blues" I believe we need them as much as they need us, in other words this is an interdependent type of relationship. I hasten to add that I do not disapprove of or in any way rule out the commercial carriers.

Your Commission on Governmental Medical Services has had and does have many problems, not the least of which is MEDICARE. Indiana began this program as the only state in the union

not having a rigid fee schedule. Due to the tremendous cooperation of the Indiana physicians the Indiana program has been such a success that I am informed now that all of the other states are following the Indiana plan. I could go on and on and take each Committee or Commission individually and discuss some phase of its activity but there is no time for this.

There are many men who would like to become more active in organized medicine. I am sorry that there are not available appointments to each and every member of our Association who are interested. However our membership can help in this way. A physician receiving an appointment to a Committee or Commission is given the opportunity to accept or reject. Most accept and make good members. But there are always a few who accept and do not function on the group to which they are appointed. In these latter cases I should like that member to notify me or our Executive Secretary that he is not able to or does not want to be a member of the group so that someone else can be named. Again the more members we have working actively in our organization the stronger the ISMA will be.

And now, gentlemen, in conclusion I want to again thank this House of Delegates for so honoring me with this office. And please believe me as being sincere when I ask you to come to me with your criticisms as well as your suggestions. In that way I can be of better service to you. ◀

* Printed in November *Journal ISMA*, pp. 1649.

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1961 Meeting

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HOUSE OF DELEGATES PROCEEDINGS

Indianapolis Session—October 23-26 1961

The House of Delegates convened at 6:00 p.m., Monday, October 23, 1961, and again at 1:30 p.m., Thursday, October 26, 1961, in the Ballroom of the Columbia Club, Indianapolis, with the president, Dr. Guy A. Owsley, Hartford City, presiding.

Dr. John W. Halsey, pastor of the First Presbyterian Church of Hartford City, gave the invocation at the opening of the first meeting.

Credentials Committee Report

On motion duly made and seconded, credentials cards presented by the delegates were accepted in lieu of a roll call at the first meeting. Dr. William E. Amy, chairman of the Reference Committee on Credentials, reported 106 delegates, seven past presidents, 12 councilors, the president, the president-elect, the treasurer, three delegates to the AMA, the editor of *The Journal*, two alternate delegates and 14 guests present.

At the second meeting, on motion of Drs. Wilder and Mason, attendance slips signed by the delegates were accepted as constituting the roll call. These slips showed 106 delegates, nine past presidents, 10 councilors, the president, the president-elect, the treasurer, the assistant treasurer, four delegates to the AMA, the editor of *The Journal*, four alternate councilors, and nine guests, present.

According to Chapter IV, Section 3, of the Bylaws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The president read Chapter XXXI, Section 1, of the Bylaws, and Article XIV of the Constitution regarding amendments to the Bylaws and Constitution.

In Memoriam

The House stood for a moment in reverence to the memory of the following physicians who had served as members of the House of Delegates, or in an official capacity in the Association, and who had passed away since the 1960 annual convention:

- HERBERT M. BAITINGER, Gary. Secretary, Lake County Medical Society, 1944-49.
WILLIAM O. BALDRIDGE, Terre Haute. Member, Committee on Civil Defense, 1950, 1952, 1953.
CHARLES R. BIRD, Indianapolis. Secretary, Decatur County Medical Society, 1910, 1920, 1921; member, Committee to Study Problems of Quackery and Nostrum Consumption, 1914-15; chairman, M-Day Committee, 1940; chairman, M-Day and Veterans' Affairs Committee, 1941-42; chairman, War Participation Committee, 1943-45; chairman, Postwar Committee, 1946.
HARRY D. BRICKLEY, Bluffton. Secretary, Wells County Medical Society, 1921, 1924.
HARRY L. BROOKS, Michigan City. Secretary, LaPorte County Medical Society, 1924-25.
ORA G. BRUBAKER, North Manchester. Secretary, Wabash County Medical Society, 1924-30; 1943-44; delegate, Wabash County, 1934-35, 1939-46, 1953; member, Public Relations Committee 1934-35; chairman, Section on Ophthalmology and Otolaryngology, 1943.
CLIFFORD E. CANADAY, New Castle. Secretary, Henry County Medical Society, 1919, 1921; delegate, Henry County 1945; member Committee on Venereal Disease, 1945; mem-

ber, Committee on Venereal and Communicable Disease, 1956.

- JAMES F. CLANCY, Hammond. Member, Committee on Lye Burns in Children, 1936.
RALPH R. COBLE, Indianapolis. Member, Committee on State Medicine, 1910-11.
CLIFFORD E. COX, Indianapolis. Member, Committee on Convention Arrangements, 1946, 1948-49.
CLAUDE DOLLENS, Oolitic. Secretary, Lawrence County Medical Society, 1908-09; delegate, Lawrence County, 1943-49; member, Committee on Prepayment of Medical and Surgical Care, 1945; member, Auditing Committee, 1948-1950; Physician of Year, 1958.
MERLIN H. DRAPER, St. Petersburg, Florida. (Formerly Fort Wayne). Member, Anti-Tuberculosis Committee, 1939-44.
JOHN H. GREEN, North Vernon. Secretary, Jennings County Medical Society, 1913-18, 1945-58; delegate, Jennings County, 1934, 1942; member, Committee on Diphtheria Prevention, 1936; member, Committee on Public Relations, 1937; member Liaison Committee with Indiana Crippled Children's Bureau, 1938-1944; chairman, Committee on Constitution and Bylaws, 1952; member, Committee on Chronic Illness, 1955.
CARL H. HABICH, Indianapolis. Member, Military Committee, 1924; Committee on Arrangements, 1931; Committee on Public Relations, 1938.
ANSON G. HURLEY, Muncie. Secretary, 1955, and President, 1957, Delaware-Blackford County Medical Society.
GARDNER C. JOHNSON, Evansville. Member, 1917, and chairman, 1929, Committee on Arrangements.
PAUL S. JOHNSON, Richmond. Secretary, 1929-30, Wayne-Union County Medical Society; chairman, Committee on Medical Education and Hospitals, 1932-33; member, 1934, and chairman 1935-36, Committee on Scientific Work; member, Committee on Veterans' Affairs, 1937; Medical Education Investigation Committee, 1938; Liaison Committee with Indiana Crippled Children's Bureau, 1939-40; Committee on Mental Health, 1941-45.
ROBERT B. JOHNSON, Hope. (Formerly Rushville). Secretary, 1946, and delegate, 1946, Rush County Medical Society.
ROBERT B. JONES, LaPorte. Member, Committee on Public Policy and Legislation, 1954.
WALTER F. KELLY, Indianapolis. Delegate, Marion County, 1934-35, 40-41; alternate AMA delegate, 1933-40; member, Committee on Arrangements, 1910-11; member, Committee on Public Policy and Legislation, 1931, 1944-47, 1952; chairman, Insurance Committee, 1932; member, Committee on Study of Health Insurance 1933-36; Committee on Expert Testimony, 1935; Committee on Industrial Health, 1940; Committee to Study Cultists and Irregular Practitioners, 1941-43; Committee on Constitution and Bylaws, 1950.
BERNARD J. LARKIN, Indianapolis. Chairman, Section on Ophthalmology and Otolaryngology, 1935; member, Committee on Public Policy and Legislation, 1937-38.
AUSTIN R. LOGAN, Petersburg. Secretary, Pike County Medical Society, 1928-38.
CARL H. McCASKEY, Indianapolis. Delegate, Marion County, 1937-41; President, Indiana State Medical Association, 1943; member, Executive Committee, 1937-46; chairman, Executive Committee, 1947-49; vice-chairman, 1921, and chairman, 1922, Eye, Ear, Nose and Throat Section; chairman 1921, Committee on Arrangements; member, Committee on Public Policy and Legislation, 1923-24; member, 1942-43, and chairman, 1944, Budget Committee; member, Committee on Indiana Inter-Professional Health Council 1943; Committee on Medical Service and Public Relations, 1945-46; Grievance Committee, 1949-50; AMA Campaign Coordinating Committee, 1949-52; Board of Appeals on Patient-Physician Relations, 1950-54; member, Committee on Hard of Hearing,

1953 and chairman, 1954; member, Committee on Conservation of Hearing, 1955.

LILLIAN B. MUELLER, Indianapolis. Secretary, 1935-40, and chairman, 1940; Section on Anesthesia.

CLEON A. NAFE, Indianapolis. Delegate, Marion County, 1946; President, Indiana State Medical Association, 1948; alternate AMA delegate, 1950-52; AMA delegate, 1953-57; member, AMA Board of Trustees and Executive Committee, 1957-61; secretary, Surgical Section, 1929; member, 1936-46, and chairman, 1947-48, Executive Committee; member, Liaison Committee with Indiana State Dept. of Public Welfare, 1939-40; Council on Medical Service and Public Relations, 1945-46; Committee on Revision of Constitution, 1946; Committee on Budget, 1947-49; Committee on Indiana Inter-Professional Health Council, 1948; ex-officio, Committee on Medical and Nursing School Scholarships, 1948; Committee on Medical Education and Hospitals, 1949-50; chairman, Indiana AMA Campaign Coordinating Committee, 1949-52; member, Anti-National Health Insurance Committee, 1953; Committee on Scientific Work, 1954; chairman, Anti-National Health Insurance Committee, 1954; member, Liaison Committee with Indiana Association of Licensed Nursing Homes, 1954, 1957; Grievance Committee, 1958-60.

EDWARD M. PITKIN, Martinsville. Delegate, Morgan County, 1934-39; member, Committee on Heart Disease, 1948.

DAVID H. RICHARDS, Vincennes. Delegate, Knox County, 1920-21; member Committee on Public Relations, 1935.

ORVILLE H. RICHER, Warsaw. Secretary, Kosciusko County Medical Society, 1922-25, 1935-37; delegate, Kosciusko County, 1940-41-43.

JOHN L. SHARP, Crawfordsville. Delegate, Montgomery County, 1935-38.

HOWARD A. STELLNER, Fort Wayne. Member, Commission on Governmental Medical Services, 1959-60.

KENNETH E. THORNBURG, Indianapolis. Delegate, Marion County, 1954.

ETTA SELSAM, Terre Haute. Member, Committee on Scientific Exhibit, 1949.

FREDERICK G. WARFEL, Indianapolis. Member, Committee to Study the Problem of Quackery and Nostrum Consumption, 1914-15; Committee on Medical Economics, 1916.

SCHULYER A. WHITSITT, Madison. Delegate, Jefferson County, 1936-37-39-48-49.

JAMES L. WYATT, Sr., Fort Wayne. Member, Committee on Public Policy and Legislation, 1956-57.

1960 MINUTES

Minutes of the meetings held at French Lick October 2 and 5, 1960, were approved as printed in the December, 1960, *Journal*, on motion of Drs. Senseny and Paris.

INTRODUCTION OF GUESTS

MR. ARVEL THARPE, president, Indiana Chapter of Student AMA.

1961 REFERENCE COMMITTEES

The chairman announced the appointment of reference committees for the 1961 session as follows:

Sections and Section Work: Norman Silverman, Terre Haute (Vigo) chairman; Truman E. Caylor, Bluffton (Wells); A. E. Stouder, Kempton (Tipton); R. Case Hammond, Evansville (Vanderburgh); Robert H. Hedgecock, Frankfort (Clinton).

Rules and Order of Business: Frank H. Green, Rushville (Rush) chairman; Floyd A. Boyer, Indianapolis (Marion); R. N. Bills, Gary (Lake); Dillon Geiger, Bloomington (Owen-Monroe); V. Earle Wiseman, Greencastle (Putnam).

Medical Education and Hospitals: Paul T. Lamey, Anderson (Madison) chairman; Howard S. Williams, Indianapolis (Marion); David L. Dunlap, South Bend (St. Joseph); Philip Todd Holland, Bloomington (Owen-Monroe); A. W. Cavins, Terre Haute (Vigo).

Legislation: Jack Shields, Brownstown (Jackson)

chairman; Ted Grissell, Indianapolis (Marion); P. J. Rosenbloom, Gary (Lake); Eugene F. Senseny, Fort Wayne (Allen); Patrick Corcoran, Evansville (Vanderburgh).

Public Relations: G. O. Larson, (LaPorte), chairman; Peter Petrich, Attica (Fountain-Warren); Lester Hoyt, Indianapolis (Marion); Frank W. Oliphant, Mount Vernon (Posey); Glen Ward Lee, Richmond (Wayne-Union).

Hygiene and Public Health: O. T. Scamahorn, Pittsboro (Hendricks) chairman; Donald G. Mason, Angola (Steuben); Guy B. Ingwell, Knox (Starke); Ralph C. Eades, Valparaiso (Porter); Eugene S. Rifner, VanBuren (Grant).

Amendments to Constitution and Bylaws: M. C. Topping, Terre Haute (Vigo) chairman; Kenneth L. Olson, South Bend (St. Joseph); T. D. Armstrong, Michigan City (LaPorte); Clarence G. Kern, Lebanon (Boone); Joseph M. Black, Seymour (Jackson).

Reports of Officers: R. B. DuBois, Lafayette (Tippecanoe) chairman; Marvin L. McClain, Scottsburg (Scott); Thomas M. Brown, Muncie (Delaware-Blackford); Ray Elledge, Hammond (Lake); Howard T. Hammel, Bedford (Lawrence).

Credentials: William E. Amy, Corydon (Harrison-Crawford) chairman; James H. Crawford, Evansville (Vanderburgh); John O. Butler, Indianapolis (Marion); E. B. Lett, Loogootee (Daviess-Martin); James W. Crain, Williamsport (Fountain-Warren).

Insurance: John Beeler, Indianapolis (Marion) chairman; Gordon B. Wilder, Anderson (Madison); David L. Adler, Columbus (Bartholomew-Brown); Kenneth Neumann, Lafayette (Tippecanoe); Stuart R. Combs, Terre Haute (Vigo).

Miscellaneous Business: William B. Challman, Mt. Vernon (Posey) chairman; V. C. Moeller, Fort Wayne (Allen); Wayne Thompson, Indianapolis (Marion); Wendell C. Stover, Boonville (Warrick); Gerald F. Kempf, Rockville (Parke-Vermillion).

REPORTS OF REFERENCE COMMITTEES

Reports of Officers

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal* of the Indiana State Medical Association, with the exception of the president's and president-elect's addresses which will be found on pages 1856 and 1862 of the December, 1961, issue.

President's address

President-elect's address

Executive Secretary (page 1404)

Treasurer (pages 1405-1408)

Chairman of Council (pages 1408-1412)

Councilors' reports (pages 1413-1416)

Executive Committee (pages 1420-1425)

Address of President of Woman's Auxiliary

Journal Editor (page 1416)

Delegates to AMA (Pages 1416-1419)

Remarks of President of Indiana Student AMA

President's Address: The address of the president, Dr. Guy A. Owsley, is printed on page 1856 of the December, 1961, *Journal* of the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. R. B. DuBois, chairman, presented the following report, which was adopted on motion of Dr. DuBois, seconded by many:

The address given by Dr. Owsley was reviewed with much pride and his dynamic presentation of the subject "Cause and Effect" of the problems facing the practice of medicine was approved.

Religious group attitudes toward socialism are not realistic but are influential in determining the course of social governmental affairs.

He pointed out that the greatest technological advances have been achieved by private and personal enterprise. Evidence was cited to show that champions of bureaucratic government would destroy these advances under the distorted but effective name of "20th century progress."

We have the tools to combat these forces. They have been effective in the past. The answer must be greater use of these tools as an organization and as individuals as suggested in Dr. Owsley's closing remarks.

We commend Dr. Owsley on his interpretation of the causes and results of bureaucratic changes in the government particularly as it applies to the progress of medicine. We recommend that the address be read by every physician in the state of Indiana.

President-elect's Address: DR. HARRY R. STIMSON, president-elect, presented an address which is printed on page 1862 of the December, 1961, *Journal* of the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. R. B. DuBois, chairman, presented the following report:

A point well taken in Dr. Stimson's address was that each of us should read the constitution and bylaws of the association.

We should also be more willing to carry out our duties as delegates and committee members of this organization.

It is also essential that we keep up the fight against the King Anderson Bill.

We wish to commend Dr. Stimson on his comprehensive presentation of the problems we are faced with in the coming years.

Mr. President, I move adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Dr. R. B. DuBois, chairman, continued with the report of the Reference Committee on Reports of Officers, as follows, which was adopted in each separate part and as a whole:

Report of Executive Secretary: We note with pride the remarks made by the Executive Secretary relative to the activities of our association and commend his office for the vigorous and incessant effort in supporting the outstanding work of our commissions in the past year.

We also note with pride his remarks pointing out that the administrative program our association organized at the inception of Medicare has been formally adopted by the Federal Government on a nationwide basis. Again we commend the secretary's office for the invaluable part it has played in the success of this program.

It pleases us to note not only the growth of our organization but also the perspective views of our secretary in regard to the future development and activities.

His official positions and participation in national affairs attests to the esteem in which he is regarded by his associates throughout the country.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Report of Treasurer: As the ISMA grows in numbers and activities so does its financial complexities increase in scope. We are delighted, of course, that our association continues to live within its economic capabilities. We extend our gratitude to Dr. Wilkens for his able work in his first year as our treasurer.

Mr. President, I move adoption of this part of the report.

(Motion seconded by many, put to vote, and carried.)

Report of Chairman of Council: The committee reviewed the report of the chairman of the Council.

The report of the emergency session December 26, 1960 (page 1408, Sept. *Journal*) was carefully studied and also the mimeographed report entitled "Report of Membership and Building Fund Contributions," dated September 1961.

To date 53% of the membership have financially supported the building program. This indicates that voluntary contribution is probably not a proper way to support the building program.

This committee recommends that a means that is administratively enforceable under the Constitution and Bylaws be established so that every member of this association pays his fair share.

The committee noted the action taken in regard to the 15-day reconfirmation procedure instituted by Blue Cross (page 1412, Sept. *Journal*). This action is supported by this committee.

This committee notes and approves the action of the council to provide for the association to become more active at the National Level (page 1412, Sept. *Journal*).

The report of the Chairman of the Council indicates that in the interim between the meetings of this association the council has done a fine job as the executive body of this association.

Mr. President, I move the adoption of this part of the report.

(Motion seconded, put to vote, and carried.)

Reports of District Councilors: The reports of the 13 councilor districts were reviewed. It is evident that each councilor has been a good organizer for his district.

The annual reports indicate that some of the councilors have produced outstanding accomplishments in their districts.

It was noticed that the district meetings were well attended. The remarks of Dr. Paris in regard to

attendance at district meetings were noted and commended (page 1413, Sept. *Journal*).

Almost every councilor report mentioned the building program and it is noted in Dr. Vye's report from the Tenth District that almost 90% of the 415 doctors have contributed. The Reference Committee recommends that the House of Delegates urge each component society and each councilor district to intensify their efforts to increase the participation of their members in this program so as to equal or surpass the record set by the Tenth District.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Report of Executive Committee: A review of the monthly reports of the Executive Committee reveals that under the capable chairmanship of Dr. Wood the committee has carried out its functions in a commendable manner.

Mr. President, I move adoption of this part of the report.

(Motion seconded, put to vote, and carried.)

Woman's Auxiliary Presidential Address: MRS. BURTON E. KINTNER, Elkhart, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House as follows:

"Burton told me all along that I should deliver my report to you from a piano bench and I should set it to music. I wish I had now, it would be much less frightening, but if I were to do so the mood of the music would be jubilant indeed, because after almost five months in office I have reason to believe that we may have a successful Auxiliary year.

"The sweet smell of success is in the air. The first indication that we had that this might be true came when we held our area meetings early in September. For these meetings or workshops the officers of the State, officers and chairman, traveled together throughout the State to the four areas and held workshops for the purpose of telling the presidents and the officers of the county auxiliary what national expects of them, what our plans for the year are, and to get ideas from them.

"The first one was held in Gary where Mrs. Harry Stimson presided and the second met in Wabash with Mrs. Bernard Hall presiding. Then we went to French Lick where Mrs. Irvin Sonne, Jr. was in charge and then in Indianapolis where Mrs. Kenneth Schneider presided—our four vice presidents.

"These area meetings were almost electric with interest. I have never seen women sit through an all-day meeting and give such unwavering attention to the very excellent presentation of the officers and chairmen.

"And I don't believe I have ever seen so many people accepting congratulations for a successful meeting. This is because so many were responsible.

"Mrs. Robert Fargher one of our members, was speaker of the day each of these four days. She talked about her own personal experience in politics in a meaningful and amusing way. And I believe that you will find as a result of this stimulus that the women who heard her are ready, willing and waiting to help you

with I-Hope or AMPAC or whatever other political or governmental activity you would require of us.

"Mrs. William Symon and Mrs. Donald Meier are our AMEF sisters from Bluffton and they gave us some good news at this time. It seemed that by the end of August they had sold over \$3,000 worth of Christmas cards for AMEF. And this was remarkable, considering that there had been no Auxiliary meetings in the counties up to this time. We were doing quite well with AMEF, I want you to know that the Christmas cards don't really take a lot of money out of your pocket because they are the same that you'd pay for them in the department stores. It's just that the company gives us the 40% profit that would ordinarily go to the department store or the sales representative.

"I think that being so much ahead of ourselves as we are this year with AMEF that we may have a chance of winning the Ethel Gastineau trophy at national. Last year the Auxiliary as a whole gave \$195,000 for AMEF, \$13,000 of which came from Indiana. We placed fourth last year.

"Mrs. Richard Potter of Randolph County is a very enthusiastic saleswoman of the *Bulletin*—our chairman of the *Bulletin*. She made an offhand remark at one of these meetings which gave me an idea that we may be progressing pretty well. The *Bulletin* is our national magazine, put out by national. It's a workbook, a manual. It may be not as entertaining as the *Saturday Evening Post* or *Playboy* or something like that, so this was an indication to me—the fact that there had been 80 new subscriptions sold in the month of July—was an indication to me of an upsurge in interest in our Auxiliary goals.

"Mrs. Otis Bowen is our Legislative Chairman and she is doing her usual good job of keeping us informed on legislative matters and telling us when to act. She gave us some good advice at the area meeting when she said that we should watch the papers and write to our Congressmen not only when we have something to talk about that may be in our own self interest but also when he's done something of which we approve—done or said something. And in that way we might expect him to listen more closely the next time we write.

"Under Beth's jurisdiction is Operation Coffee Cup. This I think is the most important thing with which the Auxiliary has been entrusted in the last 10 or 12 years. You know the AMA sent out a record made by Ronald Reagan on socialized medicine. This record was sent to every Auxiliary in the United States and each Auxiliary member is expected to play this for her friends, relatives and neighbors.

"At first some of our members were reluctant to do this. They seemed to feel that the neighbors might think they were doing it in their self-interest, to quote, "Protect our minks and our Cadillacs" unquote. But once we got started on it the reaction was quite different. Many of these women for whom we played the record had never heard of Kerr-Mills. They didn't know that there was any alternative to the government taking over medical care of people over 65. And they were mighty glad to hear that there was an alternative. And their reaction was, why don't you get this to all the people, you've got to get this out to the public. They seemed

to feel that as patients they caught on very quickly to the fact that King-Anderson means socialized medicine, and socialized medicine means the inevitable deterioration of medical care. And as patients they weren't buying it. So Operation Coffee Cup is rolling along and I think that when you consider that there are 80,000 women in the entire United States who are members of the Medical Auxiliary and if all of us are working on this we have a good chance of helping you with the defeat of King-Anderson.

"Mrs. John B. Kelly of Evansville is our Civil Defense chairman. Peg doesn't take all the credit for the newly awakened interest in civil defense. She's willing to share that with Khrushchev. Mental Health is under Mrs. Kenneth Hill; we also work on Safety—Mrs. Virgil Miller has some good ideas on its promotion.

"Mrs. William Kleifgen of Fort Wayne is in charge of Health Careers, that's nurse recruitment and scholarship. Mrs. Frank Green is our able editor of the *Hoosier Doctor's Wife*. Mrs. Albert Marshall did a wonderful job on our program book, which is financed by Blue Shield.

"Mrs. Winfred Mather is our Historian and Mrs. Joseph Black helps Mr. Converse to get the word to us and to the public about Medical Care Insurance. Mrs. Donald White is working on publicity, trying to get a good image of the Auxiliary over to the public and she is doing a good job of it.

"We no longer have a chairman of *Today's Health*, but I want you to know that all of the Auxiliaries over the State are seeing to it that there are copies of *Today's Health* in the public schools, in the public libraries.

"I can't mention names without mentioning in praise our hard-working secretaries Mrs. Emil Scamahorn is our recording secretary and Mrs. Richard Horswell is corresponding secretary and she also helps me—she acts as my secretary.

"Community service is the bailiwick of Mrs. Frank Alvey. This has received a new emphasis this year. The National Council of Churches has been compared to a Christmas decoration that we make and hang from the ceiling. It is suspended from the ceiling but has no support from the floor. Well, on the theory that it's time the floor is heard from, we are working in our churches to try to reverse this trend of the churches to support medical aid to the aged under social security. We are not working as organized Auxiliary members, or as Auxiliary members, we are working as church members who are doing what we think is right on this matter.

"Other organizations are hearing from us. The AAUW had its big convention in Washington, D.C. and their delegates went so well informed that that organization did not go for medical aid to the aged under social security. The YWCA was a little different story. Previous to their convention in Denver, the YWCA Board had met, its small Board met and went on record as favoring the social security approach, so later when it came up on the floor in Denver, the delegates had been so well prepared by the Auxiliary that it was obvious that these people would never go for this social security financing of medical aid to the aged. Therefore,

the matter was never brought up, it was never brought to a motion, there was no motion and so it stands that the YWCA, what its Board did stands as the attitude of the whole YWCA. This is the sort of thing we have to watch for.

"Mrs. Thomas Johnson of Indianapolis is our Chairman of Organization. She is our president-elect. There are 60 organized counties; 20 are unorganized and they might possibly go together into 10 organized auxiliaries. Now, there are 200 women in these unorganized counties; 75 of them paid their dues last year which is good because if they can't be active at least their dollars can be working for them. But I think you men from the unorganized counties are missing a bet in not having your women working for you. Think how many people these 200 women might be able to reach if they were working on only one thing—Operation Coffee Cup. They are a great loss and a great loss to you. As it is they are incommunicado to us. We'll do everything we can to get them organized, but I have learned that in any organization work you have to have not only a frontal attack but an attack at the flank and a few pushes from the rear. So if you will supply the pushes we'll do all we can to see that these women get organized.

"Mrs. Kenneth Schneider is in charge of membership. We gained 87 new members last year and we hope to do as well this year. I was surprised at the high proportion of membership of our auxiliary. One of our neighboring states has 10,000 physicians and 3,000 auxiliary members. We have about 4,000 physicians and almost 3,000 auxiliary members. That's a pretty high proportion.

"Mrs. Kenneth Brown and Mrs. William Tindall are our Treasurer and Financial Secretary and they take in the dues and disperse funds. We did raise the dues one dollar at the last House of Delegates. That makes it \$2.00 for State now and \$1.00 for national. We don't know yet whether this is enough with which to run our auxiliary but we will keep the strictest records possible so that we will know.

"I know you husbands of past presidents know that some of the officers and chairmen have been subsidizing the Auxiliary every year to the tune of several thousand dollars. So we hope that this can be corrected.

"The AMA apparently looks upon us as great talkers. They subscribe to the saying that you tell a woman something it will get around. For this reason they are now trying to get us well informed about the AMA itself, what it is and what it stands for. This is apparently because of COPE's 25 point propaganda attack against the AMA. So when I go around to the Auxiliaries over the state I see to it that they are well informed of the facts and the fallacies about the AMA. So that they will be in a position to refute this propaganda whenever they hear it. I must say though that it is unusual to find yourself defending the AMA against some of its own members. But this we can do if we are well informed.

"We are an Auxiliary and an auxiliary is a help. I hope that my report has given you an inkling of what a powerful lot of help 80,000 women working together could be to you. And it has been a privilege and an

honor to speak to you as the representative of the 3,000 members of *your Auxiliary*. Thank you."

REFERENCE COMMITTEE ACTION

Dr. R. B. DuBois, chairman, presented the following report:

While we are very much aware of the delightful talents and repertoire of the president of the auxiliary as a pianist and entertainer, we also found her just as talented as a speaker. The jubilation she exhibited over the successful activities of her organization could not have been more splendidly transmitted with a background of musical decor.

We can easily comprehend from her reports of auxiliary activities in regard to AMEF, state and national legislation, civil defense, rural health, mental health, safety, medical insurance, community service and its own internal improvements that the auxiliary's interests are diverse and objective.

At this time may we continue to be ever mindful of the auxiliary's worth not only to us as doctors but also to the community and to our state.

Mr. President, I move adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

The President announced that Mrs. Kintner had come to Indianapolis and had stayed to complete her duties even though her father was in a coma and was not expected to live. He passed away Wednesday evening, October 25. The House at this time stood in a moment of silence.

Dr. R. B. DuBois, chairman, continued with the report of the Reference Committee on Reports of Officers, which was adopted in each separate part and as a whole: *Editor of The Journal*: It is unfortunate that the revenue for *The Journal* from drug industry advertisement has been reduced, apparently because of the harassment of this fine industry by the Kefauver investigation.

Our *Journal* is being given national recognition for its high quality.

We commend the editor Dr. Ramsey, for a job well done.

Mr. President, I move adoption of this part of the report.

(Motion seconded, put to vote, and carried.)

Report of Delegates to AMA: The section on osteopathy which has been a controversial consideration was reviewed with unbiased feelings. The conclusion that the policy concerning the relationship of the osteopaths and the practice of medicine be considered on an individual and state level is meritorious but needs further consideration.

The section on surgical assistants was reviewed with interest. It is the opinion of the committee that the principle developed by the judicial council and the council on medical service was rational yet controversial.

We approve the report that any decisions concerning the effectiveness of drugs must be dependent on extended research, experimentation and usage, and that investing this determination in the food and drug administration would tend to limit research.

We commend the report of the delegates to the AMA

and suggest that the entire report be read by all physicians.

Mr. President, I move adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Report of Student AMA: The committee was pleased with the report submitted by Arvel Tharpe, president of Indiana Student AMA. We commend his understanding concerning the problems which now and will later present themselves. We see great need for this organization headed by such men as Mr. Tharpe and urge your support as individuals and as an association.

Mr. President, I move adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

I wish to thank the members of this committee for their participation in the preparation of this report.

Mr. President, I move the adoption of this entire report.

(Motion seconded by many, put to vote, and carried.)

Sections and Section Work

Dr. Norman M. Silverman, chairman, presented the following report, which was adopted:

The Reference Committee on Sections and Section Work met at 9:00 a.m., on Tuesday, October 24.

There were no resolutions or other business on the agenda of this Committee.

Rules and Order of Business

Dr. Frank H. Green, chairman, presented the following report, which was adopted:

It is noted by the Rules and Order of Business Committee that the conduct of the House of Delegates and its officers has been unquestioned by the members. It has not therefore been necessary to invoke this committee to action. Therefore it is the opinion of our committee that order and rules of conduct have been followed. We give this as our report.

Medical Education and Hospitals

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal of the Indiana State Medical Association*. Paragraph No. 2 of the supplemental report of the chairman of the Council, introduced before the House and referred to this committee, is printed herewith.

Student Loan Committee (page 1425)

Paragraph No. 2, supplemental report of Chairman Council:

Mr. President, members of the House: The Council heard a report of the Student Loan Committee. After hearing this report and the discussion by Dr. Ritchey and others, we moved as follows: "That the Council request the permission of this House to give to the Higher Education Loan Plan the sum of \$2,000, to be taken from the present reserves of the Association for the purpose of permitting banks of this state to loan 12½ times this amount to students in our schools of higher education."

Commission on Medical Education and Licensure
(pages 1437-1440)
Commission on Special Activities (pages 1440-1441)
Resolution No. 10—Hospital Costs
Resolution No. 11—Indiana School of Hospital
Administration

REFERENCE COMMITTEE ACTION

Dr. P. T. Lamey, chairman, presented the following report:

Student Loan: The reference committee reviewed and heard testimony on the report of the Student Loan Fund and the supplemental report referred to this reference committee by the Chairman of the Council together, as both concerned the same subject.

The committee wishes at this time to commend the committee for the completeness of their report. Our committee, after thorough discussion urges the adoption of the report of the Student Loan Committee, as printed on page 1425, Sept. *Journal*. Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Senseny, put to vote, and carried.)

Supplemental Report of Council Chairman: Your committee then discussed at length the supplemental report presented by the Chairman of the Council and recommends: That the Indiana State House of Delegates hereby give the Council permission to donate the sum of \$2000.00 to the Higher Education Loan Plan, said gift to be made from the present Student Loan Fund, and in the event there is insufficient money in the Student Loan Fund for this purpose that funds accruing from repayment of said loans be applied to this gift until the total of \$2000.00 has been accumulated.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Paris.)

(Discussed by Drs. Frank Green and Paris. **Dr. Green's motion to amend the report of the reference committee "to state that the \$2,000 gift as proposed to the Higher Education Loan Plan be withheld and that this matter be referred to the Council for further study," was seconded by Dr. Stouder, put to vote, and carried.)**

(Dr. Lamey's motion to accept this portion of the report as amended, was seconded by many, put to vote, and carried.)

Medical Education: The Reference Committee then reviewed the report of the Commission on Medical Education and Licensure and wishes at this time to commend the commission on the completeness of their report.

The Reference Committee would like to recommend that the program suggested by this commission for recruitment of young people as pre-medical and medical students as carried out in several communities and especially at Lafayette, New Albany and Columbus, Indiana and St. Joe County be instigated in every County Medical Society throughout the State. Your Reference Committee approves this report of the Commission on Medical Education and Licensure as printed on pages 1437-40, Sept. *Journal*.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

Special Activities: The Reference Committee reviewed the report of the Commission on Special Activities and wishes to commend the Commission on Special Activities for the completeness of their report.

Your Reference Committee approves the report of the Commission on Special Activities as printed on pages 1440-41, Sept. *Journal*.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 10:

Introduced by: KNOX COUNTY MEDICAL SOCIETY

Subject: HOSPITAL COSTS

WHEREAS, the rising cost of medical care has been largely the result of rising hospital costs;

WHEREAS, this increased cost reflects labor costs for the hospital;

WHEREAS, bureaucracy has a tendency to develop in nonprofit and governmental agencies;

WHEREAS, Hospital Boards and physicians do not have adequate guides regarding tables of organization, appropriate functions and numbers of employees, internal cost controls, and areas of responsibilities;

IT IS RESOLVED, that the House of Delegates of the Indiana State Medical Association instruct its delegates to the House of Delegates of the American Medical Association to introduce, at the next meeting of the AMA, an appropriate resolution requesting the AMA to initiate a study leading to the preparation of suggested guides designed to bring about more efficient hospital operation and to reduce medical care costs to the patient without being detrimental to the high quality professional care desired.

REFERENCE COMMITTEE ACTION

Dr. P. T. Lamey, chairman, presented the following report:

The next item considered was Resolution No. 10—Subject—HOSPITAL COSTS—Considerable testimony was heard by your committee on this resolution. In executive session the committee reviewed the discussion and carefully re-examined this resolution as a result of which it came to the conclusion that this resolution has a great deal of merit; however, the committee feels that since this Resolution is directed to hospital cost and care it should be amended to read as follows:

"BE IT RESOLVED, That the House of Delegates of the Indiana State Medical Association instruct its Delegates to the House of Delegates of the American Medical Association to introduce at the next meeting of the American Medical Association, an appropriate Resolution requesting the AMA to initiate a study leading to the preparation of suggested guides designed to bring about more efficient hospital operation and to reduce hospital care costs to the patient."

Mr. President, I move the adoption of this portion of this report, as amended.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 11:

Introduced by: KNOX COUNTY MEDICAL SOCIETY

Subject: INDIANA SCHOOL OF HOSPITAL ADMINISTRATION

WHEREAS, the modern hospital has an ever increasing importance in the total medical care of the patient;

WHEREAS, the modern hospital has an increasing complexity of business management in combination with clinical services;

WHEREAS, each community is developing hospitals resulting in each county in Indiana having such services available for the public;

WHEREAS, clinical experience is essential for maintaining proper administrative perspective in hospitals;

IT IS RESOLVED, that it be recommended to the proper authorities that Indiana University School of Medicine in cooperation with the School of Business develop an educational program for hospital administration.

IT IS FURTHER RESOLVED that experienced physicians be urged to enter such postgraduate training to prepare themselves for hospital administration.

REFERENCE COMMITTEE ACTION

Dr. P. T. Lamey, chairman, presented the following report:

The next item considered by your committee was Resolution No. 11, subject, "Indiana School of Hospital Administration." The reference committee, after careful study and deliberation on this resolution, was of the opinion that there had been insufficient study and exploration of such an educational program. Although, your reference committee was in sympathy with the proposal stated in the resolution, it is of the opinion that it should be referred to the proper commission for further study and recommendation to the House of Delegates at a future meeting.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Dr. Lamey continued with the report of the Reference Committee on Medical Education and Hospitals:

Your Reference Committee on Medical Education and Hospitals wishes at this time to express our sincere gratitude and appreciation to the numerous members who appeared before the Committee to testify, and as the Chairman of this Committee I wish to thank the members for their diligent service.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

Legislation

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal of the Indiana State Medical*

Association. Resolutions introduced before the House and referred to this Committee are printed herewith.

Commission on Legislation (page 1426)

Resolution No. 4—Study of Professional Incorporation Legislation and Laws

Resolution No. 6—Physicians on Hospital Boards

Resolution No. 8—Commendation of Otis Bowen, M.D.

Resolution No. 14—Physicians on Hospital Boards

Resolution No. 24—Opposing Establishment of a State Centralized Licensing Agency for Professional Licensing Boards

Resolution No. 9—Medical Care for the Aged Under Social Security

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

The Reference Committee on Legislation met at 9:00 a.m. in the basement of the Murat Temple.

The first order of business was consideration of the report of the Commission on Legislation. The following changes are recommended:

(a) an error in the seventh sentence changing it to read: "This bill allows osteopaths to practice in county hospitals, supported by *county* funds provided by *county* units of government."

(b) extend the second sentence of the third paragraph to read: "We are now faced with the King-Anderson Bill which is much like the Forand Bill except it excludes compensation for physicians other than those employed by hospitals."

This Reference Committee on Legislation commends the Commission on Legislation for its good report and diligent efforts well spent and now moves for approval of this Commission report as amended.

(Motion seconded by many, put to vote, and carried.)

The Resolutions presented to this Reference Committee numbers 4, 6, 8, 9, 14 and 24, were then considered.

Resolution No. 4:

Introduced by: GRANT COUNTY MEDICAL SOCIETY

Subject: STUDY OF PROFESSIONAL INCORPORATION LEGISLATION AND LAWS

WHEREAS, the 1961 Indiana General Assembly considered legislation which would have authorized the members of the medical, legal and other professions to conduct the practice of their professions in the form of corporations; and

WHEREAS, the proposed legislation would have permitted those electing to incorporate, whether engaged in sole or group practice of medicine, to avail themselves of certain federal tax benefits, primarily the delayed taxation of retirement funds, now denied those prohibited by the laws of their state from incorporating; and

WHEREAS, numerous other states have considered similar legislation and certain of these have enacted laws permitting professional incorporation; NOW THEREFORE

BE IT RESOLVED BY THE GRANT COUNTY MEDICAL SOCIETY, AS FOLLOWS:

That the Grant County Medical Society recommend to the House of Delegates of the Indiana State Medical Association that a study be made of professional incorporation legislation as proposed in the various states and especially the laws of the states which have enacted such legislation in order that the advantages and disadvantages to the medical profession might be determined and the effect of such legislation fully explained to the members of the Indiana Medical Association; and

BE IT FURTHER RESOLVED, that should the study of professional incorporation laws result in a determination that the same are beneficial to the medical profession, a suggested law be prepared and the Indiana State Medical Association endorse its enactment by the 1963 Indiana General Assembly; and

BE IT FURTHER RESOLVED, That professional incorporation legislation, proposed or sponsored by the Indiana Medical Association, be of such nature that the benefits shall accrue and be equally available to the sole practitioner and those engaged in group practice; and

BE IT FURTHER RESOLVED, that a copy of this resolution be presented to the House of Delegates of the Indiana Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

The Committee approves the adoption of this Resolution and strongly urges it be referred to the Legislative Commission for exhaustive study with a subsequent report to the House of Delegates in 1962.

Mr. President, I move the adoption of this section of this report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 6:

Introduced by: CLAY COUNTY MEDICAL SOCIETY

Subject: PHYSICIANS ON HOSPITAL BOARDS

We propose that the present law be amended so that physicians would be eligible for election to the board of trustees of the County Hospitals in Indiana.

Resolution No. 14:

Introduced by: PORTER COUNTY MEDICAL SOCIETY

Subject: PHYSICIANS ON HOSPITAL STAFFS

WHEREAS, certain laws relating to city and county hospitals prohibit physicians being members of the governing boards of such hospitals, and

WHEREAS, medical hospital services are becoming more and more complex, and the use of such services by the public is becoming constantly greater, and

WHEREAS, the need for professional medical opinion in the interpretation of these problems is becoming more and more evident,

BE IT THEREFORE RESOLVED THAT, the laws of Indiana pertaining to city and county hospitals which prohibit physicians being members of

the governing boards thereof be amended to permit a physician or physicians as members of such boards.

BE IT FURTHER RESOLVED THAT the Indiana State Medical Association go on record of favoring such legislation.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

RESOLUTIONS NOS. 6 and 14—Concerning Physicians on Hospital Boards, were combined under the wording of Resolution No. 14 and were approved unanimously by this Committee.

Mr. President, this Committee approves this Resolution and recommends its adoption, and I do so move.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 8:

Introduced by: ALLEN COUNTY MEDICAL SOCIETY

Subject: COMMENDATION OF OTIS BOWEN, M.D.

WHEREAS, Otis Bowen, M.D., of Bremen, Indiana, has given generously of his time in leaving an active practice to serve in the State Legislature; and

WHEREAS, this is not the first time he has done so; and

WHEREAS, he has elevated the general attitude of kindly feeling towards organized medicine in tireless effort in this pursuit as evidenced by the immediate past legislative record;

BE IT THEREFORE NOW RESOLVED, that he be given a definite commendation and vote of thanks from the House of Delegates from the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

We were real happy to make this recommendation. The Committee approves the resolution as read, with the supplemental suggestion that an appropriate token of expression of gratitude come from the Council of the Indiana State Medical Association directly.

Mr. President, this committee approves this resolution and recommends its adoption, and I do so move.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 9:

Introduced by: ALLEN COUNTY MEDICAL SOCIETY

Subject: MEDICAL CARE FOR THE AGED UNDER SOCIAL SECURITY

WHEREAS, The Allen County Medical Society has come to realize that the National Council of the Churches of Christ in the United States of America has definitely come out in favor of medical care for the aged under Social Security, and

WHEREAS, among other things, it has been disclosed that the NCCCA has done and is doing a good number of things inconsistent with the best interest of many protestant churches and contrary to the purposes to which it was formed among other things:

(1) Speaking out, as the official voice of protestantism in America, on such controversial issues as federal aid to education, the right-to-work laws, the ethical considerations of the steel dispute, the seating of Red China in the United Nations, etc.;

(2) Participating in lobbying activities before the United States Congress in fields of economic and political controversy;

(3) Refusing to repudiate mistakes or to correct misinterpretations in the press regarding actions taken by the NCCCA except in those instances where such mistakes or misinterpretations are contrary to what the professional core of the NCCCA believes and professes;

(4) Making no attempt to determine the attitude of individual Protestants but at the same time allowing the public to gain the impression that it is the voice of 39,000,000 Protestants in the United States.

NOW THEREFORE, BE IT RESOLVED:

(1) That the Indiana State Medical Association House of Delegates express its disapproval of the NCCCA's pronouncement on certain social political controversies with especial reference to the House of Delegates expressing disapproval of the attitude of the NCCCA pronouncement regarding medical care for the aged under Social Security;

(2) That this House go on record for their expressing disapproval of the manner in which these pronouncements are arrived at by the NCCCA who only presumably speaks for 39,000,000 Protestants;

(3) And that finally each individual physician regardless of religious affiliation express this disapproval to the Protestant ministers in his community as well as the Lay leaders in these particular churches.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

Resolution No. 9—Concerning the attitude of NCCCA in U. S. A. and their stand on medical care of the aged under social security:

After due deliberation and considerable testimony from interested physicians this committee has come up with the following Resolution:

WHEREAS, the Allen County Medical Society has come to realize that the National Council of Churches of Christ in the U. S. A. has come out in favor of medical care for the aged under social security, and

WHEREAS, said organization has expressed the position in favor of care to the aged under the social security system which, in the opinion of our Association, will inevitably result in inferior medical care for the senior citizens of this country and inject politics and bureaucracy into a system that now furnishes the best medical care of any country in the world; and

WHEREAS, many of our 4300 members of the ISMA have by their contributions of time and effort endeavored to further the purposes and ideals of said organization; and

WHEREAS, any clergyman, regardless of denomination, can and should speak on political, economic and social issues of importance, and

WHEREAS, such individuals have a duty and moral responsibility to be well informed citizens before making such pronouncements,

NOW THEREFORE BE IT RESOLVED: That the Indiana State Medical Association House of Delegates express its disapproval of the NCCCA in the U. S. A.'s pronouncement on medical care of the aged under social security, and

FURTHER RESOLVE: that the Indiana State Medical Association through its President send a copy of this Resolution to the National Office of said NCCCA in the U. S. A. and to each of the member Churches in the State of Indiana, and

BE IT FINALLY RESOLVED; that each individual physician regardless of religious affiliation express his opinion and views to the clergy in his community as well as to the lay leaders in his particular church.

Mr. President, I move the adoption of this amendment to the Resolution.

And Mr. President, the Committee approves the Resolution as amended and recommends its adoption, and I so move.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 24:

Introduced by: **MADISON COUNTY MEDICAL SOCIETY**

Subject: **RESOLUTION OPPOSING THE ESTABLISHMENT OF A STATE CENTRALIZED LICENSING AGENCY FOR PROFESSIONAL LICENSING BOARDS**

WHEREAS, the Governor of Indiana has appointed a Professional Licensing Board Study Committee to obtain all of the facts relative to the advantages and disadvantages and the problems involved in establishing a centralized licensing agency, and

WHEREAS, the administrative control and detail function of the Board of Medical Registration and Examination of the State of Indiana would be transferred to said central licensing agency, and

WHEREAS, the State Board of Medical Registration and Examination of Indiana has by careful and diligent work provided our citizens with excellent medical care by the most capable and qualified physicians and surgeons in the world and,

WHEREAS, a state centralized licensing agency for professional licensing boards in several other states has failed to provide their citizens with this high standard of medical and surgical care, and

WHEREAS, establishing of a centralized licensing agency would necessitate opening of the Indiana State Medical Practice Act, and

WHEREAS, the Board of Medical Registration and Examination of the State of Indiana, a self-sustaining Board, is and has been operating on a very economic budget, under the State Budget Committee. **NOW THEREFORE BE IT**

RESOLVED: That the Madison County Medical Society go on record as opposing the establishment of a centralized licensing agency for professional licensing boards, and if same is established, that the Board of Medical Registration and Examination of the State of Indiana be excluded, **AND BE IT FURTHER**

RESOLVED: That the delegates of the Madison

County Medical Society present this resolution to the House of Delegates of the Indiana State Medical Association for their consideration and approval, AND BE IT FURTHER

RESOLVED: That the Indiana State Medical Association be instructed to send a copy of this resolution to the Governor, all members of the Indiana State House of Representatives and Senate and Legislative Advisory Committee.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

The last Resolution for consideration of this Committee was RESOLUTION NO. 24 from Madison County. The Committee, after some deliberation, made some minor changes and we shall now read the amended Resolution:

WHEREAS, the Governor of Indiana has appointed a Professional Licensing Board Study Committee to obtain all of the facts relative to the advantages and disadvantages and the problems involved in establishing a centralized licensing agency, and

WHEREAS, the administrative control and detail function of the Board of Medical Registration and Examination of the State of Indiana would be transferred to said Central Licensing Agency, and

WHEREAS, the State Board of Medical Registration and Examination of Indiana has by careful and diligent work provided our citizens with excellent medical care, and

WHEREAS, a state centralized licensing agency for professional licensing boards in several other states has failed to provide their citizens with this high standard of medical and surgical care, and

WHEREAS, establishing of a centralized licensing agency would necessitate opening the Indiana State Medical Practice Act, and

WHEREAS, the Board of Medical Registration and Examination of the State of Indiana, a self-sustaining Board, is and has been operating on a very economic budget, under the State Budget Committee. NOW THEREFORE BE IT

RESOLVED: that the Indiana State Medical Association go on record as opposing the establishment of a centralized licensing agency for professional licensing boards, and if same is established, that the Board of Medical Registration and Examination of the State of Indiana be excluded, AND BE IT FURTHER

RESOLVED: That the Indiana State Medical Association be instructed to send a copy of this resolution to the Governor, all members of the Indiana State House of Representatives and Senate and Legislative Advisory Committee; and

BE IT FINALLY RESOLVED: that this be a continued study project of the permanent Commission on Legislation.

Mr. President, I move the adoption of this amendment to the Resolution.

Mr. President, the Committee approves the Resolution as amended and recommends its adoption and I so move.

(Motion seconded by many, put to vote, and carried.)

Mr. President, I move the adoption of this Reference Committee report as a whole.

Mr. President, I wish to thank Doctors Ted Grissell, P. J. Rosenbloom, Eugene Senseny, and Patrick Corcoran, the members of this Reference Committee, for their faithfulness and diligence in completing this job and also to the many individuals whose testimony made our decisions easier.

(Motion seconded by Dr. Paris, put to vote, and carried.)

Public Relations

The following matters were referred to the Reference Committee on Public Relations. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Grievance Committee report (page 1425), and the following supplementary report of the Grievance Committee:

Special Report to the Indiana State Medical Association House of Delegates, October, 1961.

Re: MEDICAL DISCIPLINE

The Council of ISMA referred to the Grievance Committee a letter from the AMA Disciplinary Committee dated July 7, 1959. The Grievance Committee considered the several important questions raised by this inquiry at its October 1959 and subsequent 1960 meetings reporting back to Council on October 2, 1960. The report was approved and presented to ISMA House of Delegates October 5, 1960. After Reference Committee hearings the report was returned with recommendations approved by the House of Delegates which directed the Grievance Committee to proceed with the study of medical discipline in Indiana in cooperation with certain of its members in key positions and again report.

Meanwhile the nation-wide survey of the AMA's Medical Discipline Committee was the subject of its June 1961 report approved by the AMA House of Delegates with little re-wording. After members of the Grievance Committee and other ISMA members had had opportunity to study the AMA report the following physicians were invited to meet with the Grievance Committee on September 17.

Guy A. Owsley, M.D., Hartford City, President, Indiana State Medical Ass'n

Harry R. Stimson, M.D., Gary, President-elect

Maurice E. Glock, M.D., Fort Wayne, Chairman of the Council

Don E. Wood, M.D., Indianapolis, Indiana University School of Medicine

Medical Members of the State Board of Medical Registration and Examination:

Hugh W. Eikenberry, M.D., Indianapolis

Paul T. Lamey, M.D., Anderson

Angelo P. Bonaventura, M.D., Hammond

Wendell C. Stover, M.D., Boonville

Frank L. Land, M.D., Fort Wayne, Chairman, Commission on Medical Education and Licensure

William N. Wishard, Jr., M.D., Chairman, Sub-Com-

mittee on Licensure, Commission on Medical Education and Licensure

Charles A. Alvey, M.D., Muncie, Chairman, Commission on Governmental Medical Services

William G. Bannon, M.D., Terre Haute, Chairman, Commission on Public Information

Lowell I. Thomas, M.D., Chairman Commission on Medical Economics

Edward T. Edwards, M.D. Vincennes, Member Commission on Medical Economics

Those present took the following action:

1) The June 1961 Conclusions and Recommendations (Section XI) of the AMA Medical Disciplinary Committee as passed by the AMA House of Delegates was approved with the following exceptions which we direct to your attention. These are:

Page 68, Section (f)—The word "primary" should be changed to "important."

Page 70, Section (g)—Dr. Glock recommends this section be accepted as written.

Page 71, Section (i)—Review and utilization committees should be set up by hospitals instead of state medical associations.

Page 72—It was the consensus that sections (g) and (i) should be disapproved.

The Grievance Committee makes the recommendation that these changes be approved by the ISMA House of Delegates and if so approved that the ISMA request through its AMA Delegates reconsideration and revision of Section XI of the Report of AMA Medical Disciplinary Committee as adopted.

The Grievance Committee further recommends in light of the need for further study of the matter of medical discipline in the State of Indiana that it be authorized by the ISMA House of Delegates to proceed.

Respectfully submitted,

Philip B. Reed, M.D., chairman

Raymond E. Nelson, M.D., vice-chairman

George L. Derhammer, M.D., secretary

William H. Garner, Sr., M.D.

Lloyd C. Marshall, M.D.

H. Allison Miller, MD.

Lowell H. Steen, M.D.

M. C. Topping, M.D.

Paul L. Stier, M.D.

Russell J. Spivey, M.D.

REPORT OF THE
MEDICAL DISCIPLINARY COMMITTEE (AMA)
to the

BOARD of TRUSTEES
AMERICAN MEDICAL ASSOCIATION

SECTION XI

Conclusions and Recommendations

The Medical Disciplinary Committee, through the various activities outlined in the preceding sections, sought to find out if satisfactory disciplinary mechanisms exist and if they are being effectively used. The results of the study show that, by and large, adequate medical disciplinary mechanisms do exist and that they are used. The frequency and effectiveness of their use, however, are less impressive. There has been a failure, in some areas, to act promptly, impartially, and objectively when the necessity arises.

Based on the belief that there is room for improvement in the discharge of medicine's disciplinary obligations and the realization that disciplinary mechanisms must be constantly reviewed and improved the committee recommends the following:

Medical Schools

It is the opinion of the committee that medical schools have not provided adequate instruction in the field of medical ethics. It is recommended, therefore, that greater efforts be made to acquaint the medical student and the young medical practitioner with ethical and proper socio-economic principles during the period of his schooling.

It is suggested specifically that:

- (a) Each medical school develop and present a required course in ethics and socio-economic principles; and
- (b) Medical schools cooperate with state boards of medical examiners and state medical associations to insure that students become acquainted with practical problems of ethics and socio-economic principles and their proper solutions.

State Boards of Medical Examiners

Your committee believes that there is a need for closer and more effective liaison and cooperation between state boards of medical examiners, medical schools, and medical associations. It further believes that certain procedural changes are worthy of consideration by the state boards. It is the recommendation of the committee, therefore, that:

- (a) Each state board of medical examiners include in all examinations for license questions on ethics and proper socio-economic practices;
- (b) Each state board of medical examiners cooperate with medical schools to the end that medical students may be acquainted with ethical and proper socio-economic principles during their period of formal schooling;
- (c) Each state board of medical examiners check the files and records of the American Medical Association, the Federation of State Medical Boards, and, if possible, every other state board of medical examiners before issuing any applicant a license to practice medicine;
- (d) Each state board of medical examiners, in cooperation with the state medical association, review the disciplinary provisions of the state's medical practice act and recommend whatever amendments are necessary to insure that they are effective in the light of current social and scientific progress;
- (e) The Federation of State Medical Boards appoint a committee to draft model rules of procedure in disciplinary cases and urge their adoption by state boards and that the American Medical Association make available to the Federation on request staff assistance to aid in this activity;
- (f) State Boards of medical examiners seriously consider the advisability and necessity of making discipline their primary responsibility;

(Recommend the Word "Primary" Should Be Changed to "Important")

- (g) Each state board of medical examiners make an annual report of its disciplinary activities to the governor of its state, sending copies of such report to the state medical association, to the American Medical Association and to the Federal and State Medical Boards;
- (h) State boards of medical examiners be urged to obtain competent legal assistance as they develop disciplinary mechanisms, recommendations, and procedures, and that they consult with such counsel at all stages of board proceedings to prevent errors which may result in litigation; and
- (i) A mechanism be established to provide an effective method of collecting and distributing, through a central source, information on disciplinary procedures as well as on licensing and disciplinary actions taken by all of the individual state medical boards.

Medical Associations

Your committee believes that state medical associations have not been as effective as they could be in the area of medical discipline because of the practice of limiting their concern to matters that are appealed to them from the local level. Some defects in basic mechanisms and considerable apathy at the county and state level in taking action against offenders have contributed to the situation which exists.

It is the recommendation of your committee, therefore, that:

- (a) State medical associations become actively concerned with the disciplinary programs of county medical societies and develop a greater interest in and knowledge of the activi-

ties of their component societies in the discharge of disciplinary obligations;

- (b) State medical associations review their disciplinary programs critically and at once to the end that changes in disciplinary mechanisms at state or local level may be made as necessary;
- (c) State medical associations develop indoctrination programs for use by their component societies to acquaint new members with ethical principles and acceptable socio-economic practices;
- (d) State medical associations continue to encourage the widest development and use of grievance committees and urge that their component societies make the services of such grievance committees more widely available;
- (e) State medical associations increase their concern and activities with respect to complaints of overcharging, medical advertising and solicitation of patients, abuse of prepayment and insurance mechanisms, as well as all other conduct inimical to the best interest of the public and the profession;
- (f) State and county medical societies utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member;
- (g) State medical associations amend their bylaws to provide that the state association may take necessary disciplinary action when it believes that serious violations of ethical principles have occurred without necessary corrective action being taken first at local level or when the state association believes that serious charges brought against an individual are not being given proper or prompt consideration by the disciplinary committee of the county medical society concerned;
(Recommend This Section (g) Be Accepted as Written)
- (h) Each state medical association and all doctors within the state give increased support to the state board of medical examiners as it seeks to obtain proper appropriations for the conduct of its affairs and that the state medical association and its membership be concerned with the selection of qualified and dedicated members for its state board of medical examiners;
- (i) Each state medical association develop and administer review and utilization committees in accord with the suggestions made in Section V of this Report; and
(Recommend That Review and Utilization Committees Should Be Set Up by Hospitals Instead of State Medical Associations)
- (j) County medical societies review their bylaw provisions relating to disciplinary procedures and revise them as necessary, using the suggested bylaws set forth in Appendix 4 of the committee's report as a model.

American Medical Association

Your committee believes that the American Medical Association should become more aggressive and active in supplying advice and assistance to state board of medical examiners and state and county medical societies in all aspects of medical discipline. It is recommended, therefore, that:

- (a) The Executive Vice-President be requested to provide this assistance, on request, through the proper department of the Association;
- (b) The American Medical Association, in cooperation with the Federation of State Medical Boards, the Council of State Governments, and other interested groups draft a model medical practice act;
- (c) The American Medical Association encourage and urge each state medical association to report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year;
(Pages 70 and 71 of AMA Report)
- (d) The American Medical Association encourage and urge the Federation of State Medical Boards to cooperate with it in developing a means whereby each state board will report promptly all major disciplinary actions taken by it to the American Medical Association;
- (e) The American Medical Association distribute annually to all senior medical students in the United States copies

of the Principles of Medical Ethics and Opinions and Reports of the Judicial Council;

- (f) The American Medical Association prepare a syllabus or lecture guide on the subjects of medical ethics, medical practice acts, and proper socio-economic conduct for the use of physicians called upon to give lectures on these subjects in medical schools, hospitals, or before medical societies;
- (g) The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level;
(Recommend that section (g) be disapproved)
- (h) The American Medical Association request that adequate lectures on ethics and proper socio-economic practices be given in all hospitals approved for internship or residency training; and
- (i) The American Medical Association instruct its representatives to the Joint Commission on Accreditation of Hospitals to urge the Joint Commission to adopt, as a requirement for accreditation the giving of adequate lectures on ethics and proper socio-economic practices each year within the hospital.
(Recommended that section (i) be disapproved)

Finally, your committee recommends that American medicine at the national, state, and local level maintain an active, aggressive, and continuing interest in medical disciplinary matters so that, by a demonstration of good faith, medicine will be permitted to continue to discipline its own members when necessary.

Medical-Legal Review Committee.

Commission on Public Information (pages 1426-27).

Paragraph No. 5, supplemental report of Chairman of Council:

Mr. President and members of the House: The Council has voted to refer the following Resolution, without recommendation to the House for their consideration in the usual manner.

"WHEREAS, the House of Delegates of the American Medical Association, with the advice of the Council on Medical Service and the opinion of the Judicial Council, did pass resolutions concerning principles of Medical Ethics at the June Annual Meeting: and

WHEREAS, the American College of Surgeons has by public pronouncement indicated that the American College of Surgeons should establish standards of conduct for the entire profession; and authority which has not been delegated by the American Medical Association; and

WHEREAS, this action is at a time when the medical profession should be united and not disrupted by schisms between groups; now therefore

BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association (1) reaffirm the approval of the House of Delegates of the American Medical Association concerning the principles of medical ethics, and (2) censor the American College of Surgeons for their action taken at their meeting in Chicago in October, 1961."

Paragraph No. 7, supplemental report of Chairman of Council: Mr. President and members of the House, the Council refers to the House without recommendation:

"AMA Support by Individual Physicians—Inasmuch as numerous efforts by certain political opponents of the American Medical Association have been made in recent months in the press and other media to dis-

credit the American Medical Association by insinuating (or by stating outright) that the Association does not have the support of the majority of practicing physicians in this country and does not represent the will of the majority of practicing physicians in this country,

BE IT RESOLVED, that the various county medical societies of the Indiana State Medical Association go on public record (by paid advertisement, if necessary) as stating emphatically that the American Medical Association does, indeed, represent their will and desire and that the present leadership of the American Medical Association enjoys the full confidence and support of the entire membership of the Indiana State Medical Association;

BE IT FURTHER RESOLVED, that other state medical associations be encouraged to do likewise in an effort to squelch, at least, this bit of misinformation currently circulating through the mass media.

REFERENCE COMMITTEE ACTION

Dr. G. O. Larson, chairman, presented the following report:

The following matters were given to the Reference Committee on Public Relations for consideration:

(1) The report of the Grievance Committee and supplemental report.

(2) Report of the Medical-Legal Review Committee.

(3) Report of the Commission on Public Information.

(4) Paragraph No. 5 of the supplemental report of the Chairman of the Council.

(5) Paragraph No. 7 of the supplemental report of the Chairman of the Council.

Grievance Committee: The Reference Committee commends the Committee on the report printed on page 1425, Sept. *Journal* and moves that the report be adopted.

(Motion seconded by many, put to vote, and carried.)

In the supplemental report of the Grievance Committee the report of the Medical Disciplinary Committee of the AMA to the Board of Trustees of the AMA was studied and the following recommendations were made:

1. On page 2, paragraph "f", the word "*primary*" should be changed to "*important*"—making the paragraph read as follows:

(f) State Boards of medical examiners seriously consider the advisability and necessity of making discipline their *important* responsibility.

Mr. President, I move the adoption of this recommendation.

2. On page 3, paragraph "f," delete the words "*as grand juries*" so that it reads:

(f) State and county medical societies utilize grievance committees to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member;

Mr. President, I move the adoption of this recommendation at this time.

(Motion seconded by many, put to vote, and carried.)

3. On page 3, paragraph "g" the Reference Committee recommends that this paragraph be referred to the Commission on Constitution and Bylaws for study.

Mr. President, I move the adoption of this recommendation at this time.

(Motion seconded by many, put to vote, and carried.)

4. On page 3, paragraph "i," we recommend that this paragraph be deleted because facilities now exist to cover this matter via the Joint Commission on Accreditation and the Indiana State Board of Health Hospital Regulation.

Mr. President, I move the adoption of this recommendation at this time.

(Seconded by many.)

(Dr. Philip Reed's amendment to this portion of the report to have the Reference Committee on Public Relations consider accepting the recommendation of the Grievance Committee's study group "that review and utilization committees should be set up by the medical staffs of hospitals instead of by state medical associations," was discussed by Dr. Glen Ward Lee, duly seconded, put to vote, and carried.)

(On voting, the original recommendations of the Reference Committee on Public Relations that paragraph "i," page 3, be deleted, was adopted.)

5. On page 3, under American Medical Association, paragraph "b," we recommend the deletion of this paragraph inasmuch as we feel it would be undesirable to open up the Medical Practice Act in the State of Indiana.

Mr. President, I move the adoption of this recommendation at this time.

(Motion seconded, put to vote, and carried.)

6. On page 4, paragraph "g," we recommend that this paragraph be disapproved.

Mr. President, I move the adoption of this recommendation at this time.

(Motion seconded, put to vote, and carried.)

7. On page 4, paragraph "i," we recommend that this paragraph be disapproved.

Mr. President, I move the adoption of this recommendation at this time.

(Motion seconded, put to vote, and carried.)

Mr. President, I move that the entire supplemental reported be approved as amended.

(Motion seconded, put to vote, and carried.)

Medical-Legal Review Committee: There was no written or verbal report presented by the Medical-Legal Review Committee.

Commission on Public Information: The report of the Commission on Public Information on pages 1426-27, Sept. *Journal*. The Reference Committee wishes to commend the Commission on this excellent report. It is recommended by this Reference Committee that the suggestion concerning the ISMA's retaining a public relations counselor be referred to the Council for study concerning the feasibility of such a proposal.

Mr. President I move the adoption of this recommendation.

(Motion seconded by Dr. Senseny, put to vote, and carried.)

It is also recommended that the Commission on Public Information submit a report, after study, of the expenditures concerned in and the utilization and actual publication of "Health Hints" and other associated information by the mass media of communication.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by many, put to vote, and carried.)

The Committee wishes to make special commendation for the work in the field of public relations done by Bartholomew and Vanderburgh counties.

Mr. President, I move the adoption of this portion of the report at this time.

(Motion seconded, put to vote, and carried.)

Supplemental Report of Chairman of Council: Section 5 was presented by the Council without recommendation. The Reference Committee presents an amended version as follows:

WHEREAS the House of Delegates of the American Medical Association, with the advice of the Council on Medical Service and the opinion of the Judicial Council, did pass resolutions concerning principles of Medical Ethics at the June Annual Meeting, and

WHEREAS the American College of Surgeons has permitted public pronouncement which has embarrassed the medical profession as a whole; now therefore

BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association 1) reaffirm the approval of the House of Delegates of the American Medical Association concerning the principles of Medical Ethics, and 2) deplore any action by any group of doctors which results in such unfortunate publicity.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Section 7 was also presented by the Council without recommendation. The Reference Committee recommends the adoption of this section of the report after deletion of the parenthetical expression "*by paid advertisement, if necessary*" in line 2, paragraph 2, and the substitution of the phrase, "*overwhelming majority of the membership*" for "*entire membership*" in line 5, paragraph 2.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

Dr. Larson expressed his thanks to every member of the committee for their excellent work on the committee and also to those who testified before the committee.

Hygiene and Public Health

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports

will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Public Health (pages 1428-30), and the following supplementary report, presented by Dr. Emmett B. Lamb, chairman:

"President Owsley, and members of the House of Delegates: The Commission on Public Health has a short supplemental report which is in the form a resolution, which we would like to introduce at this time. This resolution deals with the clinic or ambulatory treatment of the narcotic addict. It reads as follows:

"WHEREAS, the American Medical Association, the American Bar Association and the Commission on Public Health, of the Indiana State Medical Association, have had committees studying the problem of narcotic drug addiction, and;

"WHEREAS, it has been concluded that the only adequate and successful treatment of narcotic addiction necessitates constant control in a secure institution affording a drug-free environment, and;

"WHEREAS, experience has shown that treatment of narcotic addiction by means of various types of ambulatory clinic plans has been universally unsuccessful, impractical and scientifically unsound, and;

"WHEREAS, in attempts of treatment of narcotic addiction by ambulatory methods, addiction has in fact generally increased;

"THEREFORE, BE IT RESOLVED, that the Commission on Public Health, of the Indiana State Medical Association recommends opposing the ambulatory clinic plan for the treatment of narcotic addiction, and;

"BE IT FURTHER RESOLVED, that this Resolution be presented to the House of Delegates of the Indiana State Medical Association for their consideration and approval, and;

"BE IT FURTHER RESOLVED, that the Indiana State Medical Association Delegates to the American Medical Association be instructed:

- (a) To oppose the development of such ambulatory treatment plans, and;
- (b) To support
 - (1) After complete withdrawal, follow-up treatment, including that available at rehabilitation centers;
 - (2) Measures designed to permit the compulsory civil commitment of drug addicts for treatment in a drug-free environment;
 - (3) The advancement of methods and measures towards rehabilitation of the addict under continuing civil commitment, and;
 - (4) The establishment of methods for the dissemination of factual information on narcotic addiction to the members of the medical profession."

Commission on Voluntary Health Agencies (pages 1430-35)

Resolution No. 1—Resolution Rejecting the Ambulatory Clinic Plan Treatment for Narcotic Addiction

Resolution No. 12—Accreditation of Nursing Homes, Indiana

Maternal Mortality Report for 1960. (Copy handed to each delegate)

Resolution No. 23—Creation of Committee of Indiana State Medical Association to Act in Liaison with Military and Civil Authorities in the Procurement of Medical Military Personnel

REFERENCE COMMITTEE ACTION

Dr. O. T. Scamahorn, chairman, presented the following report:

The Reference Committee on Hygiene and Public Health met in the downstairs dining room of the Murat Temple, at 9:00 a.m., Tuesday, October 24, 1961. All the members were present. The meeting was called to order by the chairman, who appointed Dr. E. S. Rifner as temporary secretary

Resolution No. 12:

Introduced by: KNOX COUNTY MEDICAL SOCIETY

Subject: ACCREDITATION OF NURSING HOMES, INDIANA

WHEREAS, many persons are being cared for in nursing homes without clearly defined distinctions of the extent of professional care provided;

WHEREAS, the Indiana State Board of Health licenses and inspects the physical facilities of such nursing homes;

WHEREAS, the Indiana Nursing Home Association exists as a responsible body composed of the owners and operators with objectives for improving the standards of such homes;

WHEREAS, it is difficult for insurance companies to underwrite nursing home care without more detailed clinical descriptions of patients in nursing homes—chronic illness, convalescent, domiciliary;

WHEREAS, there is no present accrediting agency for professional care in nursing homes in Indiana;

BE IT RESOLVED THAT the Indiana State Medical Association in cooperation with the Indiana Nursing Home Association and the Indiana State Board of Health establish classes of nursing homes based on clinical grounds, establish feasible standards of patient care, provide inspection mechanism to maintain such safeguards for the patient.

REFERENCE COMMITTEE ACTION

Dr. O. T. Scamahorn, chairman, presented the following report:

The first order of business was the consideration of Resolution No. 12—Accreditation of Nursing Homes in Indiana.

Mr. President, the Reference Committee approves this Resolution as written and recommends its adoption and I do so move.

(Motion seconded, put to vote, and carried.)

Voluntary Health Agencies: The second order of business was the Report of the Voluntary Health Agencies' Commission. The reference committee recommends that the report be accepted as written. The committee wishes to commend the members of the Commission on Voluntary Health Agencies for their diligent work in the

past two years. Their ardent devotion to the duties of their commission is most commendable.

Mr. President, this committee approves the report and recommends its adoption and I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 23:

Introduced by: PHILIP E. YUNKER, M.D., DELEGATE FROM LAGRANGE COUNTY

Subject: CREATION OF COMMITTEE OF THE INDIANA STATE MEDICAL ASSOCIATION TO ACT IN LIAISON WITH MILITARY AND CIVIL AUTHORITIES IN THE PROCUREMENT OF MEDICAL MILITARY PERSONNEL

WHEREAS, there exist throughout the world conflicts which threaten to plunge the world again into war, and

WHEREAS, the development of modern warfare threatens the citizens of the United States and their American way of life, and

WHEREAS, the Indiana State Medical Association, subscribing fully to the maintenance of peace and neutrality, believes that national unity and prepared national defense offer the best means for defending our nation and the American way of living against these conditions, NOW THEREFORE

BE IT RESOLVED: that the president of the Indiana State Medical Association be authorized to constitute and empower a committee to act in liaison with proper military and civilian authorities and veterans' organizations to make a complete study for, and prepare a detailed program for medical cooperation and preparedness in the event a shooting war becomes a reality, to the end that in such event an effective program is established whereby first: the medical needs of the military; second: the proper medical care at home during a military emergency, and

BE IT FURTHER RESOLVED: that this committee be organized immediately and that contacts be made with proper military authorities so that work may be begun in the operation of our defense position, both at home and abroad.

REFERENCE COMMITTEE ACTION

Dr. O. T. Scamahorn, chairman, presented the following report:

The third order of business was Resolution No. 23—Creation of Committee of the Indiana State Medical Association to Act in Liaison with Military and Civil Authorities in the Procurement of Medical Military Personnel. The Reference Committee approves this Resolution and recommends its adoption, and I do so move.

(Motion seconded by Dr. Paris, put to vote, and carried.)

Resolution No. 1:

Introduced by: MADISON COUNTY MEDICAL SOCIETY

Subject: RESOLUTION REJECTING THE AMBULATORY CLINIC PLAN TREATMENT FOR NARCOTIC ADDICTION

WHEREAS, the American Medical Association and the American Bar Association have had committees study the problem of narcotic drug addiction, and

WHEREAS, the only adequate and successful treatment of narcotic addiction necessitates constant control in a secure institution affording a drug-free environment, and

WHEREAS, experience has shown that treatment of narcotic addiction by means of various types of ambulatory clinic plans has been universally unsuccessful, impractical and scientifically unsound, and

WHEREAS, in all attempts of treatment of narcotic addiction by ambulatory methods, addiction has in fact increased; THEREFORE

BE IT RESOLVED, that the Madison County Medical Society go on record opposing the ambulatory clinic plan for the treatment of narcotic addiction, and

BE IT FURTHER RESOLVED, that the Delegates of the Madison County Medical Society presents this resolution to the House of Delegates of the Indiana State Medical Association for their consideration and approval, and

BE IT FURTHER RESOLVED, that the Indiana State Medical Association Delegates to the American Medical Association be instructed to oppose the development of any such ambulatory treatment plans, and that they be instructed to recommend and support measures designed to require the compulsory civil commitment of drug addicts for treatment in drug-free institutions, (2) to advance methods and measures towards rehabilitation of the addict, and (3) to establish methods for the dissemination of factual information on narcotic addiction to the members of the medical profession.

REFERENCE COMMITTEE ACTION

Dr. O. T. Scamahorn, chairman, presented the following report:

The fourth consideration of this Committee was Resolution No. 1—Rejecting the Ambulatory Clinic Plan Treatment for Narcotic Addiction. The Committee reviewed this resolution and the resolution presented before the House of Delegates by Dr. Lamb, as a supplementary report of the Commission on Public Health. This committee, after much deliberation and discussion, recommends that Dr. Lamb's resolution be adopted for its more positive approach.

Mr. President, this committee disapproves Resolution No. 1 and recommends the adoption of the supplementary Resolution of the Commission on Public Health and I do so move.

(Motion seconded, put to vote, and carried.)

Public Health: The fifth consideration of this Committee was the report of the Commission on Public Health. The committee reviewed the actions of the Commission on Public Health in detail. It wishes to express its commendation to the Committee on Rural Health for their planning and execution of Junior-Senior Day and desires in this manner to inspire this committee to continue its efforts. We also wish to commend the liaison between this committee and the Indiana State Board of Health concerning preventive medicine and the reports on narcotic addiction.

Mr. President, this committee approves this report and recommends its adoption and I do so move.

(Motion seconded, put to vote, and carried.)

Maternal Mortality Report for 1959: This sixth subject to come before this Committee was the Maternal Mortality Report. The committee wishes to emphasize the content of this report to the House of Delegates and recommend that this improvement in Maternal Health Care receive publicity from the delegates.

The committee wishes to thank the committee making this report possible for its excellent summary of what must have been a very time consuming task.

Mr. President, this committee approves this report and recommends its adoption and I do so move.

(Motion seconded by Dr. Senseny, put to vote and carried.)

The committee wishes to thank those members who appeared before it and discussed the above resolutions and reports and for their participation and interest and the chairman wishes to thank the members of this committee for their diligent service.

Mr. President, we move the adoption of this report in its entirety.

(Motion seconded, put to vote, and carried.)

Amendments to Constitution And Bylaws

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Constitution and Bylaws (pages 158-161, Handbook).

Section 3, supplemental report of Council Chairman:

Mr. President, members of the House: Inasmuch as it has been the policy of this Association to adopt the principles of medical ethics of the AMA as the principles of ethics of the Indiana State Medical Association, and inasmuch as the House of Delegates of the AMA took action in June to enunciate a new policy as same refers to relationships between doctors of medicine and doctors of osteopathy. The Council recommends we reaffirm our policy of accepting the ethics of the AMA as ethics of the ISMA on this subject. The AMA statement is as follows:

"Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

Resolution No. 2—Refund of Dues of Deceased Members.

Resolution No. 3—Mandatory Assessment against New Members.

Resolution No. 13—Amendment to Bylaws Establishing a Section on Nervous and Mental Diseases.

Resolution No. 15—To Amend Chapter IV, House of Delegates of the Indiana State Medical Association Bylaws.

Resolution No. 16—Changing Name of "Section on Medicine" to "Section on Internal Medicine."

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

This committee was asked to report on the following items referred by the House of Delegates:

Report of the Commission on Constitution and Bylaws: It was brought to the attention of your Reference Committee by the Miami County Delegate that their resolution on voting had been reported out of context by the commission and had not been printed in the *Journal* either as a resolution or in the report of the commission, although it had been submitted in November of 1960. Since it was to be considered by this committee as a separate resolution, resubmitted as Resolution No. 15, this part of the report of the commission was tabled.

The following resolutions for changes in the Bylaws submitted by the commission and made a part of the record of the last meeting of the House were studied. It is to be noted for your information that if you vote to accept this report, you will be amending the Bylaws as recommended by the commission in each instance.

(1) Be it resolved that the first sentence of the third paragraph of Section 2 of Chapter IV of the bylaws be amended by deleting the word "December" therefrom, and substituting the word "February."

As amended it would read:

"The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association on or before February first prior to the annual convention at which such delegates are to serve."

Mr. President, we recommend acceptance of this part of the report.

(Motion seconded by Dr. Senseny, put to vote, and carried.)

(2) Be it resolved that Section 10 of Chapter XXVI of the Bylaws be amended by deleting the word "August" therefrom and substituting the word "February."

As amended it would read: "At the annual business meeting for election of other officers, in advance of the annual convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before February first."

Mr. President, we recommend the acceptance of this part of the report.

(Motion seconded, put to vote, and carried.)

(3) Be it resolved that the third paragraph of Section 12 of Chapter XXVI of the Bylaws be amended by deleting \$10.00 therefrom and substituting the phrase "fifty percent of the annual dues."

As amended this would read: "... Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay fifty percent of the annual dues for the remainder of that year."

Mr. President, we recommend the acceptance of this part of the report.

(Motion seconded, put to vote, and carried.)

(4) Be it resolved that the last sentence of Section 1 of Chapter II of the Bylaws be amended by deleting the title, "Committee on Scientific Work" and substituting the title, "Commission on Convention Arrangements."

As amended this would read: "... The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers."

Mr. President, we recommend the acceptance of this part of the report.

(Motion seconded, put to vote, and carried.)

(5) Be it resolved that the second sentence of Section 4 of Chapter II of the Bylaws be amended by deleting therefrom the title, "Committee on Convention Arrangements" and substituting the title, "Commission on Convention Arrangements."

As amended this will read: "... The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made."

Mr. President, we recommend the acceptance of this part of the report.

(Motion seconded, put to vote, and carried.)

(6) Be it resolved that Section 5 of Chapter IV of the Bylaws which now reads: "Funds may be appropriated by the House of Delegates subject to approval of the Council, for such purposes as will promote the welfare of the Association and the profession," be replaced in toto by a new Section 5 to read:

"Sec. 5—Proposals calling for appropriations of funds by the House of Delegates shall be submitted to the Council for its recommendation before final action of the House."

This proposal occasioned considerable debate before this Committee and at first reading it would appear to be taking away some authority of the House. Upon deeper consideration, however, it was found that heretofore any appropriation made by the House was subject to the approval of the Council and it could change or remand the action of the House by action of the Council. This proposed change, while tending to halt hasty appropriations or assessments by referring them

to the Council for their recommendations, still leaves the ultimate decision to the House. We therefore approve of this Resolution.

Mr. President, we recommend the acceptance of this part of the report.

(Motion seconded, put to vote, and carried.)

The remaining portion of the report of the Commission consisted in outlining the subjects to be covered in future work of the Commission. This committee wishes to commend the members of the Commission on Constitution and Bylaws for the work that has been done and recommends their continuing zeal in following their plans for future work.

Mr. President, I move the adoption of the report of the Commission on Constitution and Bylaws as amended.

(Motion seconded by many, put to vote, and carried.)

Section 3, Supplemental Report of the Chairman of the Council: This section has to do with changes in policy of the AMA in relationships between doctors of medicine and doctors of osteopathy. We have adopted the Principles of Medical Ethics of the AMA as the Principles of Ethics of the ISMA. Since this change in policy would in effect, if not ratified by this Association, require a change in our Bylaws to Chapter XXVIII, Section 2, this portion of the report was referred to this Committee.

The prime function of your Reference Committee, therefore, in its consideration of this report was concerned with its ramifications as to its constitutionality on the state level.

Much evidence was heard on local problems with osteopathic practitioners. Evidence was heard of instances in which doctors of medicine were required by law to conduct a professional association with osteopaths on hospital staffs.

Instances were cited of voluntary professional relationships with doctors of osteopathy practicing a cult system of healing. Other evidence was heard that voluntary association with an osteopath endeavoring to practice a scientific method of healing would tend to raise his standard of practice. Pleas were made for the State Association to take a definite stand either for or against any professional associations by its members with an osteopath. We also had opinions expressed that the problem was one for local county society consideration and could not be implemented on a statewide basis.

After consideration of all of the discussion on this issue it is the recommendation of this Committee that Section 3 of the supplementary report of the Council be accepted, but that it is still the responsibility of the Council to aid the local county medical societies in solving their local problems, when requested, and the Council should be more active in this field of endeavor.

It is also recommended that the Commission on Legislation study local situations by which the State Association might bring a possible change in the law to strengthen and clarify the regulations to control of practice in tax supported hospitals.

We do not recommend change in our Bylaws if this section of the report is adopted.

Mr. President, we recommend acceptance of Section

3 of the report of the Council and I move the adoption of this part of our report.

(Motion seconded; discussed by Dr. Kubley; lost on standing vote.)

Resolution No. 2:

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: REFUND OF DUES OF DECEASED MEMBERS

WHEREAS, it is now the rigid policy of the Indiana State Medical Association not to refund dues to the widows of deceased members who died during the current (dues paying) year, and

WHEREAS, in specific instances in which widows have requested such refunds they have been refused by the Indiana State Medical Association but have been refunded dues by component County Societies; and

WHEREAS, the total amount of money that would in any calendar year be refunded would represent a very small fraction of the total dues collected by the Indiana State Medical Association; and

WHEREAS, the refunding of dues at such time of sadness would undoubtedly be looked upon as an expression of great kindness and sympathetic understanding; THEREFORE,

BE IT RESOLVED, that the St. Joseph County Medical Society recommend that the Indiana State Medical Association refund dues paid in the current year by members to the estates of those physicians who die in the calendar year in which dues are paid, and

BE IT FURTHER RESOLVED, that the delegates to the Indiana State Medical Convention from St. Joseph County present this resolution to the entire House of Delegates for a vote at the next regularly scheduled meeting in October, 1961.

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution No. 2: We concur in the spirit of this Resolution and recommend its adoption with this change in wording:

"Be it Resolved, that the Indiana State Medical Association refund dues paid in the current year by members to the estates of those physicians who die prior to October 1 in the calendar year in which dues are paid, when requested by the estate through the county society."

Mr. President, I move the adoption of this Resolution as amended.

(Motion seconded, put to vote, and carried.)

Resolution No. 3:

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: MANDATORY ASSESSMENT AGAINST NEW MEMBERS

WHEREAS, The ruling of the House of Delegates of the Indiana State Medical Association in regular session in October, 1960, made mandatory a \$50.00 pledge to be paid either as a donation or as a forced loan; and

WHEREAS, upon protest by numerous counties the legal advisors to the Indiana State Medical Association proclaimed that the aforementioned ruling was unenforceable; and

WHEREAS, the ruling was never actually rescinded but remains in the record; and

WHEREAS, the Council in session April 9, 1961, rules that all new physicians joining the Society after the above mentioned date would be expected to assist the Building Fund by such forced donation or loan; and

WHEREAS, this taxation on doctors as yet unborn, is in essence contrary to the basic political philosophy of the Indiana State Medical Association and the American Medical Association; and

WHEREAS, the mandatory assessment now made against new members but not against present members therefore becomes discriminatory legislation in a democratic organization; and

WHEREAS, the doctors as yet unborn have no legal recourse; therefore

BE IT RESOLVED, that the St. Joseph County Medical Society recommend to the Indiana State Medical Association that present members and future members will not be forced to contribute to the Indiana State Medical Association Building Fund.

BE IT FURTHER RESOLVED, In addition that no special assessment, contribution, donation, loan or initiation fee will be levied against new members.

BE IT FURTHER RESOLVED, that the original legislation demanding this levy be rescinded to make it read "voluntary contribution."

BE IT FURTHER RESOLVED, that the Delegate to the Indiana State Medical Convention from St. Joseph County present this resolution to the entire House of Delegates for a vote at the next regularly scheduled meeting in October, 1961.

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution No. 3: There was complete unanimity of the opinions expressed before this Committee on this Resolution. No one spoke against it. We therefore approve this resolution.

Mr. President, I move the adoption of this Resolution.
(Motion seconded, put to vote, and carried.)

Resolution No. 13:

Introduced by: EARL W. MERICLE, M.D.

Subject: AMENDMENT TO THE BYLAWS
ESTABLISHING A SECTION ON
NERVOUS AND MENTAL DIS-
EASES

BE IT RESOLVED: That Chapter III, Section 1 of the Bylaws be amended by adding thereto "i. Nervous and Mental Diseases," and

BE IT FURTHER RESOLVED that the present paragraph "i" be titled "j."

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution No. 13: This resolution constitutes an amendment to the Bylaws establishing a Section on Nervous and Mental Diseases. Since this resolution was submitted and made a part of the record of the last meeting of the House, your adoption of this resolution at this time will constitute this amendment.

"Be it resolved, that Chapter III, Section 1 of the

Bylaws be amended by adding thereto "i. Nervous and Mental Diseases."

"Be it further resolved that the present paragraphs (i) be title (j)."

Mr. President, I move the adoption of this resolution.
(Motion seconded, put to vote, and carried.)

Resolution No. 15:

Introduced by: MIAMI COUNTY MEDICAL SOCIETY

Subject: TO AMEND CHAPTER IV:
HOUSE OF DELEGATES, OF THE
ISMA BYLAWS

WHEREAS, organized medicine should be a truly representative form of government; and

WHEREAS, the delegates to the Indiana State Medical Association's House of Delegates are merely representatives of the constituent members of the various County Medical Societies; and

WHEREAS, each member of the ISMA should have the right to know how his representative did, in fact, vote on any issue brought before the House of Delegates; and

WHEREAS, under the existing system being used by the House of Delegates, in that oral or standing votes are not made as a matter of record how each member of the House of Delegates did, in fact, vote.

THEREFORE BE IT RESOLVED: that Chapter IV, of the Bylaws of the ISMA be amended by adding a new Section 8 as follows:

SECTION 8: The *final* vote of any issue except the election of officers, is required to be by roll call vote, and each member's vote will be permanently recorded and published in the *Journal*, and no suspension of this rule will be allowed on the *final* vote of any issue. An additional meeting on another day, is required to allow time for caucus and reconsideration after the issues are brought out of reference committee before a final vote is taken, and the final meeting allows no further debate on any issue.

BE IT FURTHER RESOLVED: that a similar resolution be submitted by the ISMA Delegation to the AMA House of Delegates.

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution No. 15: This resolution from Miami County was most ably spoken to and supported by the delegate from that county. It seeks to amend the Bylaws by adding a new Section to Chapter IV making a roll call vote mandatory in the House on any issue except the election of officers and the recording and publication of each delegate's vote. It also requires an additional meeting of the House on another day.

It was again brought to the attention of the committee that this resolution although presented in November 1960, was not published in the *Journal* and therefore did not reach the attention of the membership at large as wished by Miami County. It developed that the prime purpose of the resolution was to attempt a solution of the problem of communication, to not only stimulate more interest in the membership at large but to recognize their desire to be more considered in the deliberations of the House and to make the delegate

more responsible to his constituents for his actions in the House. To this end our committee was sympathetic to the aims of Miami County and wish to commend them for their efforts in this direction.

For the House to attempt to implement this Resolution as written, however, would obviously complicate the proceedings to the extent that we feel it to be most impractical. We do believe that some method of recording and publishing the votes on issues of importance, at the discretion of the chairman, should be given consideration. To this end, we recommend that the Commission on Constitutions and Bylaws be given this problem for further study and recommendation.

We recommend the rejection of this resolution.

Mr. President, I move the adoption of this part of the report.

(Motion seconded.)

Discussed by Dr. Lloyd Hill who moved to amend the recommendation of the Reference Committee "that the Commission on Constitution and Bylaws be given this problem for further study and recommendation at the next annual meeting of the ISMA." Motion seconded, put to vote, and carried.

(Dr. Topping moved the adoption of this portion of the report as amended. Motion seconded, put to vote, and carried.)

Resolution No. 16:

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: CHANGING NAME OF "SECTION ON MEDICINE" TO "SECTION ON INTERNAL MEDICINE"

WHEREAS, the "Section on Medicine" originally represented all physicians other than surgeons and obstetricians, and

WHEREAS, many physicians formerly members of this section are now affiliated with a section of more specialized interest, and

WHEREAS, past record shows that those physicians attended meetings of this section and serving as its officers have been almost without exception doctors especially interested in internal medicine, and

WHEREAS, internists compose the largest group of specialists in ISMA not organized into its own section, NOW THEREFORE

BE IT RESOLVED: That the section of the ISMA now described as "Section on Medicine" be changed to "Section on Internal Medicine," and that this resolution be introduced in the House of Delegates of the Indiana State Medical Association at its next meeting in October, 1961.

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution No. 16: This Resolution constitutes an amendment to the Bylaws changing the name of the Section on Medicine to the Section on Internal Medicine. Since this Resolution was presented and made a part of the record of the last meeting of the House your adoption of it at this time will constitute this amendment. Your Committee reports favorably on it.

Mr. President, I move the adoption of this resolution.

(Motion seconded, put to vote, and carried.)

I wish to thank the members of this Committee: Dr. Olson, Dr. Armstrong, Dr. Kern, and Dr. Black for their work and collaborations in the preparation of this report. We also thank the many members who appeared before the Committee.

Mr. President, I move the adoption of this report as a whole, as amended.

(Motion seconded, put to vote, and carried.)

Insurance

The following matters were referred to the Reference Committee on Insurance. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Economics and Insurance report (pages 1435-1436).

Report of William Harry Howard, M.D., president of Blue Shield.

Resolution No. 26—Non-indemnity Type Insurance to Be Offered by Blue Shield.

Resolution No. 17—Proposing Joint Study of Medical Care Costs.

Paragraph No. 4, Supplemental Report of Council Chairman.

Mr. President and members of the House: The Executive Committee referred the following motion to the Council and the Council voted to refer this to the House of Delegates.

"Meeting, September 17, 1961—Grievance Committee—Dr. Topping made the motion that the Grievance Committee should ask the Executive Committee to check into a blanket insurance policy which is available to cover the Indiana State Medical Association and members of the county medical societies who are serving on local grievance committees."

REFERENCE COMMITTEE ACTION

Dr. John Beeler, chairman, presented the following report:

Your Reference Committee on Insurance met at 9:00 a.m., October 24, 1961, in the basement dining room of the Murat Temple. Members present were Drs. John M. Beeler, chairman, David L. Adler, Gordon B. Wilder, Kenneth Neumann and Stuart R. Combs. Approximately 25-30 members of the Indiana State Medical Association were present, as well as representatives of Blue Shield. Spirited discussion was held on each of the matters referred to your committee. We are grateful for the advice and cooperation of those who attended the meetings of the committee and we wish to thank them for their participation in these deliberations. *Report of Commission on*

Medical Economics and Insurance:

The first item considered was the Report of the Commission on Medical Economics and Insurance. The work of this commission was delegated to four sub-committees;

A:—Prepaid Insurance of Aged.

B:—Minimum Standards for Insurance; and Cooperative care of the Surgical Patient.

C:—Nursing Homes and Medical Foundations.

D:—Blue Cross-Blue Shield, Pathology and X-Ray Transfer.

Your Reference Committee accepts the reports of Sub-Committees A, B, and C as printed in the Sept. *Journal*, page 1435. The Committee also accepts the report of Sub-Committee D, as printed on pages 1435-36, Sept. *Journal*. Your Reference Committee regrets that no constructive action has been taken during 1961 to effect the transfer of payment for professional services of Pathologists and Radiologists from Blue Cross to Blue Shield. The Committee recognizes the sincere desire of the specialists for this transfer. The opposition of hospital administrators and boards of trustees, and the reluctance of the board of directors of Blue Cross thus far have combined to block this transfer. This committee further urges the Board of Directors of Blue Shield to increase their efforts to effect this transfer. Your committee feels most strongly that this transfer will be in the best interests of patients and physicians and the Commission on Medical Economics and Insurance is urged to further this continuing effort.

Your Reference Committee feels compelled to state that no effective liaison exists between the State Medical Association and the physician members of the board of Blue Cross. The committee attests to the high calibre of these physicians but feels that the Council and/or the Executive Committee should specifically invite these physicians to attend their meetings so that the Council and/or the Executive Committee may be informed of the deliberations of the Board of Directors of Blue Cross and the physicians members of the Board can avail themselves of the opinions and desires of organized medicine in this state.

Your Reference Committee urges also that close liaison be established between the physician members of the Boards of Directors of Blue Cross and Blue Shield. Only in this way can cooperation be insured and both plans prosper.

Mr. President I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 26, introduced by the Council of ISMA: subject, NON-INDEMNITY TYPE INSURANCE TO BE OFFERED BY BLUE SHIELD.

RESOLVED, That the Indiana State Medical Association recommend and encourage Blue Shield to offer to the Public of Indiana, a payment plan for medical care, similar to Medicare, which plan will have no schedule of indemnities; but Blue Shield will pay the regular charges made by physicians in the areas in which the services are rendered, and that the County Medical Societies and the Indiana State Medical Association be urged to establish advisory committees for the purpose of assisting Blue Shield in developing such a plan, and generally assisting Blue Shield in the operation of the plan.

REFERENCE COMMITTEE ACTION

Dr. John Beeler, chairman, presented the following report:

The next item considered was the special report of Dr. Harry Howard. His report was considered along with Resolution No. 26. The major portion of the meeting of your committee was devoted to these two items. Much discussion by members of the Indiana State Medical Association and by representatives of Blue Shield was to the effect that some type of pay-all contracts would soon have to be written in Indiana if Blue Shield is to compete favorably for contracts which Blue Shield feels they are in danger of losing. After the open meeting of your committee closed and during its later deliberations, additional members of our State Association made known their viewpoints. These were often diametrically opposed to opinions expressed previously during the open meeting. Because of this a second meeting of the committee was held at 10:00 a.m. Wednesday to hear additional views. At this second meeting, after further discussion, it was found that the immediate urgency of any decision could be delayed for several months in order to better inform the general membership at the local level. Your committee, therefore, recommend that any action on resolution No. 26 be delayed at this time, and that each county medical society be furnished with complete information by the ISMA and Blue Shield. We further petition the officers of this Society to call a special meeting of the House of Delegates, no later than February, 1962, to take final action. Your committee takes this action because:

1. The Commission on Medical Economics and Insurance has not previously studied this proposal.

2. Members of the House of Delegates have not been previously instructed by their local county medical societies on this matter.

3. No unanimity of opinion was expressed at the meeting of your committee.

4. No clear and present emergency exists which should compel a relatively hasty decision at this session of the House of Delegates.

5. Such a clear departure from past policy should not be hastily adopted.

Mr. President: I move the adoption of this portion of the report.

(Motion seconded, discussed by Dr. Edwards, put to vote and carried.)

Resolution No. 17:

Introduced by: THE COUNCIL OF THE ISMA
Subject: RESOLUTION PROPOSING JOINT
STUDY OF MEDICAL CARE
COSTS

WHEREAS, it behooves the medical profession in all Indiana communities to have an awareness of the economics of medical care and to exert leadership in its own as well as related fields in regards to modern-day financing in the area of health services; and

WHEREAS, such services must be tendered at the lowest possible figure consistent with the best quality of care and in keeping with economic factors attendant upon the purveyors of health services; and

WHEREAS, influences relating to the economics of modern medical care revolve not only upon the medical profession but upon hospitals, health insurance indemnifiers, underwriters, patients and others; and

WHEREAS, because of the many complexities involved in arriving at a reliable and complete analysis of the economics related to today's disbursements for all health services; now

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association, through initiation by its properly designated officials, assume leadership in establishment of a Joint Committee on the Economics of Modern Health Services; and

BE IT FURTHER RESOLVED that the following groups be invited to join with the Indiana State Medical Association in committee membership:

Blue Cross of Indiana, Blue Shield of Indiana, Indiana Hospital Association, Indiana Health Insurance Council and that each of the said groups, including the State Medical Association, name three representatives to membership on the committee; and

BE IT FURTHER RESOLVED that such committee will launch research studies related to the economics of modern-day medical care, develop suggestions and recommendations pertinent to the total involvement and undertake adoption of such recommendations by each participating group.

REFERENCE COMMITTEE ACTION

Dr. Beeler continued with the report of the Reference Committee on Insurance:

The next item considered was Resolution No. 17. Your committee recommends approval of this resolution, as printed and distributed.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote and carried.)

Supplemental Report of Council Chairman: The next item considered was paragraph 4 of the Supplemental Report of the Chairman of the Council. Your committee approves the motion of Dr. Topping, made to the Executive Committee and referred to the Council, and in turn referred by the Council to your Reference Committee on Insurance. We recommend that this matter be referred to the Commission on Medical Economics and Insurance for implementation.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Finally, Mr. President, the acoustics in the basement of the Murat Temple are very poor and important testimony is frequently impossible to be clearly heard. Your committee strongly urges some change in the location of Reference Committee hearings at future meetings of this Society in Indianapolis.

Mr. President, I want to thank the members of this committee for their diligent work.

Mr. President, I move this report be adopted in its entirety.

(Motion seconded, put to vote and carried.)

Miscellaneous Business

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the September, 1961, Vol. 54, No. 9, *Journal* of the Indiana State Medical Association, with the exception of the report

of the Building Committee, which is printed below. Resolutions introduced before the House and referred to this committee also are printed herewith.

Commission on Convention Arrangements (no printed report).

Commission on Governmental Medical Services (pages 1427-28), and the following supplementary report, presented by Dr. Charles R. Alvey, chairman:

Mr. President, members of the House of Delegates: This is an informational report. At the first Conference on Disaster Preparedness sponsored by the Commission on Governmental Medical Services we had a registration of 35. This year we had a registration of 96, this being our second meeting. This represented people from all over the State and in many different occupations, not only physicians but all fields of medicine and allied professions. We have already started work on the one for next year and we would like to ask that you all work on this in your own communities. Thank you.

Commission on Inter-Professional Relations (pages 1436-37).

Commission on Aging (pages 1441-42).

Resolution No. 5—To Change the Procedure of Examination of Applicants for Disability Under Social Security.

Resolution No. 7—Formation of Definite Policy Regarding Osteopathic-M. D. Relationship.

Resolution No. 18—Allocation of A. M. E. F. Contributions.

Resolution No. 19—Independent Living.

Resolution No. 20—Standard Health and Medical Procedures for County Homes.

Resolution No. 21—County Medical Society Liaison with Local Group or Groups.

Resolution No. 22—Geriatric Rehabilitation Services.

Resolution No. 25—Declaring Consultations with Osteopathic Physicians an Ethical Procedure.

Building Committee report.

Building Committee Report:

REPORT OF THE BUILDING COMMITTEE

Your building committee welcomes this opportunity to bring you a progress report of their activities since the last meeting of the House of Delegates.

While the assignment given to us a year ago was, we realized, to be a difficult and arduous one, our experience has proved that we were given a project of no small proportions! It would have been of interest to the committee had we maintained a log of the hours spent by the members in planning and bringing the project to the present status.

During the progress of our work, we have maintained close contact with both the executive committee and the Council, seeking their advice and keeping them fully informed of the activities of our committee.

Following a thorough study of the functions of our headquarters office, the report of the management survey firm, and the findings of previous committees which had studied the problem of a headquarters building, we immediately went into serious discussions with the architects on the requirements for a building.

Your committee felt that in developing this building we should make every effort to be far sighted, and do our best to anticipate the future needs of our association

as to space and facilities, keeping in mind at all times the financial limitations which had been placed upon us by the House.

Plans were finalized and placed for bid, with June 19 set as the date for opening bids. I don't mind telling you that when the first bid was opened, the members of your committee had the wind literally knocked out of them, but finally regained some air, hoping that this was not to be the pattern of the rest of bids. The first was some \$150,000 higher than the estimate of the construction cost which the committee had been given. However, we soon found that the pattern had been set and, had a camera caught the expressions on our faces as each bid was opened, I am sure it would have shown our chins dropping lower and lower.

When we finished, the lowest bid was some \$140,000 above our limit!

The next question was, "What do we do now?" We called the lowest bidder and requested that he immediately meet with us, which he was kind enough to do. Along with the architects and the contractor, we said, "What can be done to get this building within our budget?" So a complete new study immediately began and several suggestions were made. Following several meetings with the builder and the architects, we finally arrived at some conclusions. We reported our experience to the Council and to the executive committee, and requested permission to negotiate a contract for a building at a price we were authorized to pay. This was granted and the negotiations undertaken.

Originally we had planned a large basement area which would have served many purposes, such as an expansion area of work space, or a room which in future years could have been converted into an auditorium or meeting room space. This room would have been approximately the same size as the room in which you are now meeting. Also, we had planned a larger area for staff work space, and a building so constructed to permit the construction of additional floors in the future should the need arise.

The final upshot was that we had to eliminate the large basement area, a good chunk of the floor space for work area, and type of construction which would permit the building of additional floors in the future.

In reducing the floor area we shortened the length of the building, leaving space for the construction of an additional wing should it be found necessary in the future.

It goes without saying that your committee is happy to report that contracts were signed and construction actually got under way on August 29 of this year. You will all have an opportunity to see the progress of this construction on Thursday, when the cornerstone will be laid with proper ceremonies.

The basic contract calls for an expenditure of \$276,000 for the construction of the building. There will be a variation in this figure before the completion of the building. We have decided to go on the open market and take our own bids for carpeting as study and prices received indicate that by so doing we can carpet a larger area of the building for very little more money than bid by the contractor. Also, it will be necessary that the drive and parking area be paved as

this was a requirement when the property was rezoned.

By next April we hope that we can hand you your new home, ready for occupancy, and that we will be able to say, "Here is the result of our efforts . . . we have built the best we could with the money we had to spend . . . and we hope that it pleases you, and will serve as a functional asset in the further development of our fast-growing association."

We hope that as time passes, more of the members will see fit to join those who have assisted financially, and give or lend their money to this project. If a larger number would lend this assistance, it is entirely possible that it might not be necessary for the association to borrow funds for completion of this project.

REFERENCE COMMITTEE ACTION

Dr. William B. Challman, chairman, presented the following report:

The Reference Committee on Miscellaneous Business met in the downstairs dining room of the Murat Temple at 9:00 a.m., Tuesday, October 24, 1961.

Convention Arrangements: The Scientific Program constitutes the report of this Commission. We wish to commend this commission on the excellency of this program and scientific exhibits which have been presented at this convention.

Governmental Medical Services: This report was carefully considered, reviewed and approved.

Mr. President, we move that this section of the report be adopted.

(Motion seconded, put to vote and carried.)

Inter-Professional Relations: This report was carefully considered, reviewed and approved.

Mr. President, we move that this section of the report be adopted.

(Motion seconded, put to vote and carried.)

Aging: This report was carefully considered, reviewed and approved.

Resolution No. 19:

Subject: INDEPENDENT LIVING

WHEREAS, In a democracy, it is conceived that an individual should live in dignity and by his own initiative and effort maintains as complete a state of independence as possible throughout his lifetime; and

WHEREAS, Events and situations occur to an individual at different times during his life which if not corrected or relieved result in dependency; and

WHEREAS, A person's independency may be more nearly assured when only services which are absolutely necessary to restore him to self-sufficiency are made available; and

WHEREAS, The provision of service and assistance when not absolutely necessary promotes and encourages a continuing and increasing dependency complex; THEREFORE BE IT

RESOLVED, That the Indiana State Board of Health, along with the State Medical Association and other appropriate official and voluntary agencies, be encouraged to study the causes that lead to the institutionalization of the aged, physically and mentally handicapped and the chronically ill, and to explore ways by which such individuals may be enabled to maintain their independent living status for the longest possible period of time, BE IT FURTHER

RESOLVED, That the State Board of Health and the previously mentioned organizations and groups, upon the basis of their findings, recommend a plan for effecting a program of independent living for the State of Indiana.

Resolution No. 20:

Subject: STANDARD HEALTH AND MEDICAL PROCEDURES FOR COUNTY HOMES

WHEREAS, a recent survey of county homes conducted by the State Board of Health and the Governor's Commission on Aging demonstrates that many of these homes do not require a medical examination on admission; and

WHEREAS, many of these same homes do not provide for periodic medical examinations of their residents and have no well-established policies on medical procedure; THEREFORE BE IT

RESOLVED, that the State Board of Health study these problems for the purpose of developing a medical examination form to be used by county homes with all admissions and, BE IT FURTHER

RESOLVED, that the State Board of Health with the assistance of other appropriate groups, develop and recommend standard health and medical procedures to those responsible for the administration of county homes and; BE IT FURTHER

RESOLVED, that the State Board of Health should work closely with County Commissioners in implementing the above recommended action.

Resolution No. 21:

Subject: COUNTY MEDICAL SOCIETY LIAISON WITH LOCAL GROUP OR GROUPS

WHEREAS, there is a continued increase of aged and aging in the population; and

WHEREAS, more and more individuals and groups are developing concern for the medical problems faced by the senior citizens; and

WHEREAS, good health or the absence of good health and the availability of medical care are important considerations in relation to any program concerned with the aging; and

WHEREAS, there is not a single county in the state that does not have within its confines nursing homes and/or county homes, and organized programs concerned with aging; THEREFORE BE IT

RESOLVED, that each county medical society establish a committee or designate one of its members to serve as liaison with these institutions or groups in order that practical and acceptable health and medical care practices may be implemented.

Resolution No. 22:

Subject: GERIATRIC REHABILITATION SERVICES

WHEREAS, it is generally agreed that many of the residents of county homes and nursing homes can benefit materially from rehabilitation services; and

WHEREAS, studies and observation indicates that rehabilitation services are practically non-existent in these institutions; and

WHEREAS, it is generally believed that best results will be achieved when rehabilitation services are ad-

ministered by personnel of the institutions who are caring for the residents; THEREFORE, BE IT

RESOLVED, that the State Board of Health develop a plan and a procedure by which a continuous program of training in the elementary principles of rehabilitation can be provided for the personnel of county homes and nursing homes; BE IT FURTHER

RESOLVED, that in the event resolutions, "Independent Living"; "Standard Health and Medical Procedures for County Homes"; "County Medical Society Liaison with Local Group or Groups" and, "Geriatric Rehabilitation Services" are approved, active support be given to the efforts of the State Board of Health in securing the necessary budget to carry out these activities.

REFERENCE COMMITTEE ACTION

Dr. Challman continued with the report of the Reference Committee on Miscellaneous Business:

Resolution No. 19, Independent Living, Resolution No. 20, Standard Health and Medical Procedures for County Homes, Resolution No. 21, County Medical Society Liaison with Local Group or Groups, and Resolution No. 22, Geriatric Rehabilitation Services, are really a part of the Commission on Aging report. All resolutions were read and approved.

Mr. President, we move that this section of the report be adopted.

(Motion seconded, put to vote and carried.)

Resolution No. 5:

Introduced by: MONTGOMERY COUNTY MEDICAL SOCIETY

Subject: RESOLUTION TO CHANGE THE PROCEDURE OF EXAMINATION OF APPLICANTS FOR DISABILITY UNDER SOCIAL SECURITY

WHEREAS, an applicant for Social Security, because of disability is now sent to his personal physician at the expense of applicant, and

WHEREAS, the attending physician has to complete a long examination form which is sent to the district office of Social Security, and

WHEREAS, the Social Security office then orders many applicants to certain physicians in Lafayette, Indiana, to repeat the examination, this time at the expense of Social Security and at great inconvenience to the applicant, NOW THEREFORE,

BE IT RESOLVED, that the Social Security be advised that a short statement by attending physician should be sufficient, and

FURTHER, it is suggested that where possible, final examination of applicant be done in his own community.

REFERENCE COMMITTEE ACTION

Dr. William B. Challman, chairman, presented the following report:

5. RESOLUTION No. 5 (RESOLUTION TO CHANGE THE PROCEDURE OF EXAMINATION OF APPLICANTS FOR DISABILITY UNDER SOCIAL SECURITY.) After considerable discussion it was decided that most of the confusion resulted from lack of information and the Committee recommends that the examining physician carefully and

completely fill out the examination forms. In most cases the social security office will have no trouble in deciding the merits of the case and examination by another physician will not be necessary.

For your information, the social security system has a movie which is available to any society covering this material which will lead to a more complete understanding of the problem. Therefore, your Committee recommends the rejection of this Resolution.

Mr. President, we move that this section of the report be adopted.

(Motion seconded, put to vote and carried.)

Resolution No. 7:

Introduced by: MARSHALL COUNTY MEDICAL SOCIETY

Subject: FORMATION OF DEFINITE POLICY REGARDING OSTEOPATHIC-M. D. RELATIONSHIP

WHEREAS, the Indiana State Medical Association is the legislative, executive, and judicial representative of all county medical societies of the State of Indiana, we the Marshall County Medical Society find the above organization derelict in its duties in representing the doctors of the state in regard to the Medical Doctors-Osteopathic situation.

We further find that the State Medical Association, along with the American Medical Association did not take the initiative and foresight to aid the component societies having an osteopathic problem in executive and legislative powers, especially in lobbying of the past state legislature, where there was discrimination against county tax-supported hospitals. We feel that all City, Township, County, and State tax-supported hospitals should be open to practitioners of the healing arts, if it is to be a just law.

THEREFORE, we justly resolve that the State organization take to task:

- (1) The problem of osteopathic physician and M.D. relationship and form a definite policy that we on the county level can follow.
- (2) To promote legislation that is not discriminating against county tax-supported hospitals.

REFERENCE COMMITTEE ACTION

Dr. William B. Challman, chairman, presented the following report:

Resolution No. 7 (Formation of Definite Policy Regarding Osteopathic-M.D. Relationship). Your committee recommends the rejection of this Resolution for the following reasons: That certain counties having tax-supported county hospitals have no alternative under the law other than to accept the osteopaths on their staffs provided they qualify under, and abide by, the rules and regulations of the hospital. The committee feels that control of these osteopaths must be instituted at the local level in conformity with the usual procedure followed by the hospitals and medical staffs in controlling physicians under similar circumstances in each particular county. The committee further feels that the State Association stands ready to assist a local society when so requested in any matter.

We do not feel that the state society can at this time form a blanket policy toward osteopathy in general, and

that it should conform to the recommendations of the American Medical Association as set forth on pages 1439-40, Sept. *Journal*. The last paragraph of this specifically states that each case must be individually considered. It is impractical for the State Association to investigate each and every individual osteopath and that this only can be done by the physicians in the county who have close contact with them and are in a position to know of his qualifications.

Mr. President, we move that this section of the report be adopted.

(Motion seconded; discussed by Drs. Kubley, Petrich, Paris, Glock, Dunlap, Shields and Crain; put to vote, and report of the Reference Committee adopted.)

Resolution No. 18:

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: ALLOCATION OF A. M. E. F. CONTRIBUTIONS

WHEREAS, the annual dues of I.S.M.A. include a contribution to A.M.E.F., and

WHEREAS, every graduate of a medical school has filial devotion to his alma mater, and

WHEREAS, the A.M.E.F. contribution is distributed proportionately among all medical schools unless designated for a specific school by the member for a particular year: NOW THEREFORE

BE IT RESOLVED, That the portion of I.S.M.A. dues allocated to A.M.E.F. hereafter collected be given to schools of medicine from which the member graduated provided, however, that each member may, at his option, specify another school, either on an annual or a continuing basis, and that the official record of such distribution be maintained by the headquarters office of I.S.M.A.; AND BE IT FURTHER

RESOLVED, That this Resolution be presented to the House of Delegates of I.S.M.A., October 23, 1961.

REFERENCE COMMITTEE ACTION

Dr. William B. Challman, chairman, presented the following report:

Resolution No. 18: (Allocation of A.M.E.F. Contributions) Your Committee, after careful consideration, recommends that this resolution be rejected because the same end can be accomplished simply by the individual indicating to which school his contribution should be assigned. It is recommended that county secretaries again call this to the attention of their members.

Mr. President, we move that this section of the report be adopted.

(Motion seconded, put to vote and carried.)

Building Committee:

Dr. William B. Challman, chairman, presented the following report:

The Building Committee Report was carefully read, reviewed and approved. The Building Committee should be commended for the tremendous amount of effort and time that they have expended on behalf of the Association.

Mr. President, we move that this section of the report be adopted.

(Motion seconded, put to vote and carried.)

Resolution No. 25:

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: RESOLUTION DECLARING CONSULTATIONS WITH OSTEOPATHIC PHYSICIANS AN ETHICAL PROCEDURE

WHEREAS, There are forty-five licensed Osteopathic Physicians and Surgeons practicing in the County; and

WHEREAS, There is a one-hundred bed State approved Osteopathic Hospital in South Bend; and

WHEREAS, Members of St. Joseph County Medical Society are frequently requested to consult with Osteopathic Physicians in the diagnosis and treatment of people in this community; and

WHEREAS, The American Medical Association has recently altered their views on medical practice by Osteopaths and has recommended that policy by set by the individual State Societies; therefore

BE IT RESOLVED, That Indiana State Medical Association go on record in declaring that consultation with Osteopathic Physicians is an accepted procedure in ethical medical practice.

REFERENCE COMMITTEE ACTION

Dr. William B. Challman, chairman, presented the following report:

Resolution No. 25 (Resolution Declaring Consultations with Osteopathic Physicians an Ethical Procedure): This resolution was carefully considered and reviewed and the Reference Committee generally approves of the principle enunciated here but believe for clarity the last "Whereas" and the "Be It Resolved" should be changed to read as follows:

WHEREAS, the American Medical Association has recently altered its views on relationship between osteopaths and doctors of medicine and has recommended that policy be implemented by the constituent medical associations on a state or local basis; THEREFORE

BE IT RESOLVED, that the Indiana State Medical Association go on record in declaring that consultation with osteopathic physicians is an accepted procedure in ethical medical practice when so determined at the local level that the doctor of osteopathy does in fact practice a system of healing founded on a scientific basis.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote and carried.)

Mr. President, I wish to thank the members of my committee and the numerous interested people who appeared before us to testify.

Mr. President, we move the adoption of this report in its entirety.

(Motion seconded by many, put to vote and carried.)

Election of Officers

The following officers were elected:

President-elect—Maurice E. Glock, M.D., Fort Wayne

Treasurer—Irvine W. Wilkens, M.D., Indianapolis

Assistant Treasurer—Charles F. Gillespie, M.D., Indianapolis

AMA delegates and alternates for term expiring December 31, 1963:

Delegates: Walter L. Portteus, M.D., Franklin

Jack E. Shields, M.D., Brownstown

Alternates: William B. Challman, M.D., Mount Vernon

John M. Paris, M.D., New Albany

Address of President-Elect

Thank you very much. I pledge that I'll serve you to the best of my ability. When I take office finally, I figure that I'll need about 4,000 members working real hard to save this organization. I'll appreciate all the help you can give me. Thank you.

Place of 1963 Annual Convention

Dr. John Beeler, on behalf of the Marion County Medical Society, invited the Association to hold its 1963 convention in Indianapolis and the invitation was accepted by consent.

Resolutions of Appreciation

Dr. Frank Green presented the following resolutions of appreciation and commendation:

(1) WHEREAS, the medical profession has an age-old history of providing health and related services to distressed peoples wherever they may be; and

WHEREAS, such activities are in the best tradition of the medical profession and bear witness to the solemnity of the Hippocratic oath; now

THEREFORE, BE IT RESOLVED that the House of Delegates of the Indiana States Medical Association does hereby commend the action of Drs. Richard M. Nay, Robert D. Pickett, James M. Jay, Hunter A. Soper, B. T. Maxam and Herbert Sedam in providing medical service to the distressed population of the Congo; and

BE IT FURTHER RESOLVED that the Indiana area of the Methodist Church be commended in providing transportation and hospital facilities for the aforementioned physicians in their programs of mercy.

(2) WHEREAS, the success of any meeting or convention depends in large measure to the advance planning, effort and work of many individuals; and

WHEREAS, the success of this, the 112th annual convention of the Indiana State Medical Association, has depended to such a large extent upon the efforts of numerous individuals; now

BE IT RESOLVED that the House of Delegates, in convention assembled, does hereby extend its thanks and gratitude to Dr. James M. Leffel, chairman of the general convention arrangements committee, and to the members of his commission; and

BE IT FURTHER RESOLVED that a copy of this resolution be sent to Dr. Leffel and members of said commission as well as to the members of the other various committees responsible for the numerous events concerned with the 112th annual convention.

(3) WHEREAS, the communications media—press, radio and television—have been generous and considerate in their reportorial and public service time in behalf of the medical profession; and

WHEREAS, the media has reflected this time-honored attitude in their coverage of this, the 112th annual convention of the Indiana State Medical Association; and

WHEREAS, the medical profession has a full realization of the necessity for and the importance of a free media in a democratic society; now

BE IT RESOLVED that the House of Delegates of the Indiana State Medical Association, in convention assembled, does hereby extend its thanks and appreciation to the communications media for its consideration of the activities of this convention as well as for its support and help in the past.

(4) WHEREAS, the 112th annual convention of the Indiana State Medical Association has been greatly enhanced by the largest number of scientific exhibits ever assembled for any convention of said association; and

WHEREAS, the education opportunities offered and made available to members of this Association have been of untold benefit in their practical application for individual physician members of this Association; now

BE IT RESOLVED that the House of Delegates, in convention assembled, does hereby extend its appreciation and gratitude to Dr. Edward B. Smith, chairman of scientific exhibits; and

BE IT FURTHER RESOLVED that said House of Delegates does also express its gratitude to the many organizations, schools and individuals who were responsible for the said exhibits.

(5) WHEREAS, the large array of technical exhibits on display at the 112th annual convention of the Indiana State Medical Association has contributed greatly to the success of the convention; and

WHEREAS, said exhibits enabled individual members of the Association to gain useful and valuable

information into the complexities of the modern-day practice of medicine; now

BE IT RESOLVED that the House of Delegates, in convention assembled, does hereby extend its thanks to said technical exhibitors for their many contributions to the quality of this convention.

(6) WHEREAS, the presidency of the Indiana State Medical Association requires an ever-increasing amount of time and effort as association activities increase; and

WHEREAS, the past year has reflected this increased burden; and

WHEREAS, the president of this Association is, in performance of his official duties, called upon to attend numerous meetings, including many of considerable distance; and

WHEREAS, these activities require an unusual sacrifice of time at considerable personal inconvenience to the president; and

WHEREAS, the outgoing president of this Association has so conducted himself as to reflect lasting and great credit to the medical profession of Indiana; now

THEREFORE BE IT RESOLVED that the House of Delegates of the Indiana State Medical Association, in convention assembled, does hereby extend with heartfelt thanks its lasting gratitude and appreciation to Dr. Guy A. Owsley for his outstanding services to the Association during the tenure of his office.

Mr. President, I move the adoption of these resolutions.

(Motion seconded unanimously.)

Adjournment

The House adjourned, *sine die*, at 4:15 p.m., Thursday, October 26, 1961.

Association News

EXECUTIVE COMMITTEE

October 23, 1961

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.

Ralph Hamill, attorney; Ralph V. Everly, M.D., chairman, Building Committee, and James A. Waggener, executive secretary.

Membership Report

Number of members as of Dec. 31, 1960----- 4,309

1961 members as of Sept. 30, 1961:

Full dues paying ----- 3,659

Residents and interns ----- 197

Council remitted ----- 40

Senior ----- 376

Honorary ----- 3

Military ----- 37

Total 1961 members as of Sept. 30, 1961----- 4,312

Number of members as of Sept. 30, 1960----- 4,275

Gain over last year ----- 37

Number of AMA members as of Sept. 30, 1960_ 4,137

Total 1961 AMA members as of Sept. 30, 1961_ 4,192

Gain over last year----- 55

1961 AMA members: Dues paying---- 3,535

Exempt, but active----- 657

4,192

Number who have paid state dues but not AMA
dues for 1961----- 120

Building Committee

The following resolution, presented by the chairman of the Building Committee, authorizing the chairman of the Building Committee to sign change orders dealing with the construction of the building, such orders to be attested to by the Executive Secretary, was adopted on motion of Drs. Glock and Covalt:

WHEREAS, a construction contract for the Headquarters Building was entered into under date of August 29, 1961, and which contract provides for the execution of certain instruments and papers in connection therewith, such as change orders, and

WHEREAS, such instruments and papers need to be executed promptly in the expediting of the construction of said building;

BE IT RESOLVED, that the Chairman of the Building Committee, or the Vice-Chairman of said Committee, be authorized to approve and execute all instruments and papers required or authorized to be executed or approved by the Indiana State Medical Association under the terms of said construction contract, such instruments and papers to be attested to by the Executive Secretary.

The following resolution authorizing the Building Committee to enter into contracts for the carpeting of the new building and for paving of the parking lot was approved on motion of Drs. Owsley and Covalt:

WHEREAS a construction contract for the Headquarters Building was entered into under date of August 29, 1961, and

WHEREAS carpeting and paving of the drive and parking lot were deleted from said contract, and furnishings were not included in the said contract;

NOW BE IT RESOLVED that the Building Committee be, and it now is, authorized to enter into contract for said carpeting and furnishings and to do all things needed to complete said building and make the same ready for occupancy; and

BE IT FURTHER RESOLVED that the Building Committee be, and it is authorized, to receive bids for paving the drive and parking lot and to let a contract therefor to the bidder who, in its judgment, submits the lowest and best bid therefor, providing that the letting of such contract does not cause the total cost to exceed the sum of four hundred thousand dollars (\$400,000.00).

A change order was submitted for the approval of the Executive Committee calling for the removal of additional trees at the rear of the lot to make room for the utility lines, at a cost of \$100.00, which was approved on motion of Drs. Owsley and Covalt.

The Building Committee requested that before signing this change order that the utility company be contacted to see if they would remove the trees at their expense.

Headquarters Office

The executive secretary was instructed to investigate an insurance policy which would cover the officers of the Indiana State Medical Association while traveling on business for the Association.

Treasurer's Office

The treasurer reported on the statement of Income and Expenses as of Sept. 30, 1961, and reviewed the audit by the auditors, Wolf and Company. The report was accepted by consent.

Legislative Matters

The co-chairman of the Commission on Legislation reported on the recent AMA meeting, the United States Chamber of Commerce meeting, and the proposed legislation on federal scholarships.

The committee discussed thoroughly Resolution No. 9, Medical Care for the Aged Under Social Security, which was to come before the House of Delegates.

Organization Matters

AMA Delegates' Expenses. Payment of AMA delegates' expenses, as proposed by Dr. Glock at the September 16 meeting of the Committee, and report on the survey made by mail, were discussed and the following action taken:

On motion of Drs. Glock and Owsley the delegates are to be paid \$30.00 per day for the actual days of the meeting, plus one additional day, plus first class round trip travel fare.

On motion of Drs. Glock and Owsley the president, president-elect, the chairman of the Council, chairman of the Executive Committee, and the alternate

delegates are to be reimbursed on the same basis for attending AMA meetings.

On motion of Drs. Glock and Wilkens the officers, delegates and alternate delegates are to meet on Sunday evening preceding the opening of the sessions of the American Medical Association, at which time a discussion is to be held of the matters to come before the American Medical Association and for the purpose of electing a chairman of the delegation and a spokesman or floor leader, for the purpose of considering resolutions, with each member being assigned to a particular reference committee.

On motion of Drs. Glock and Owsley a breakfast meeting of the delegation is to be held each day during the AMA sessions.

On motion of Drs. Glock and Owsley the secretary is to maintain a current list of Council and committee appointments and elections to come before the AMA House of Delegates.

On motion of Drs. Glock and Owsley the president and the executive secretary are to make recommendations to the speaker of the House of Delegates of the AMA for placement of Indiana delegates on reference committees.

By consent it was agreed that all delegates and alternate delegates are to be requested to supply information indicating their general field of interest in AMA affairs and activities.

The motion adopted by the Grievance Committee requesting an investigation of an insurance plan to cover members of the state Grievance Committee and county society grievance committees was referred to the House of Delegates upon motion of Drs. Glock and Covalt.

Letter from the president of the Kentucky State Medical Association was read for the information of the Committee.

Letter requesting the Association to cooperate in the nomination of an individual to receive the President's Award for Employment of the Physically Handicapped was referred to the appropriate commission on motion of Drs. Covalt and Wilkens.

A resolution requesting the Auxiliary to hold its annual meeting at the same time and place as the annual convention of the Indiana State Medical Association was withheld inasmuch as this would come before the Council.

A resolution presented by Dr. Stimson in which Blue Shield is requested to adopt a no-fee schedule contract for offering to the public of Indiana was referred to the Council without recommendation, upon motion of Drs. Glock and Covalt.

1961 Annual Convention

Matters dealing with the annual convention, such as the sale of exhibit space, arrangements and program, the exhibitors' party, plans for the annual dinner and for the cornerstone laying, were all approved by consent.

Dr. Glock called attention to a recent announcement of the American College of Surgeons and proposed a resolution from Allen County dealing with this subject which was referred to the Council on motion of Drs. Owsley and Covalt.

Future Meetings

On motion of Drs. Glock and Owsley, Dr. Alvey or a member of his Commission, or a member so designated by him, is to attend the 12th County Medical Societies Conference on Disaster Medical Care in Chicago on Nov. 4 and 5, 1961.

On motion of Drs. Stimson and Covalt, action was deferred on the forthcoming meeting of the U. S. Chamber of Commerce Public Affairs Conference, to be held in Washington, D. C., Jan. 24 and 25, 1962.

On motion of Drs. Glock and Covalt the appropriate Commission is to be authorized to send a representative to the National Conference on Mental Health to be held in Chicago on Feb. 2 and 3, 1962.

Resolutions to Come Before House of Delegates

The Committee reviewed the resolutions to come before the House of Delegates. On motion of Dr. Glock, taken by consent, the members of the Executive Committee were to urge that Resolution No. 8 be adopted and that the members of the Committee use their influence to see that this is accomplished.

On motion of Drs. Covalt and Owsley the remarks of appreciation given by Dr. Wood and Dr. Wilkens were accepted.

There being no further business the Committee adjourned to meet again for reorganization on Thursday, October 26, 1961.

EXECUTIVE COMMITTEE

October 26, 1961

Present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.

Ralph V. Everly, M.D., chairman, Building Committee; Gordon B. Wilder, M.D., and Ralph Hamill, attorney.

The purpose of this meeting was to discuss certain

information that had been attributed to some of the members of the Committee dealing with the operation of the new headquarters building.

It was recommended that the Building Committee make a thorough analysis of the building operating expenses and that they prepare facts and figures as they know them at this time on the estimated operating expenses for the new building. Also they were to investigate what is the estimated maintenance cost of this property.

There being no further business, the meeting adjourned.

EXECUTIVE COMMITTEE

October 26, 1961

The Executive Committee was called to order in the Beefsteak Room of the Columbia Club, October 26, 1961, following the close of the Council meeting, with the following members present:

Harry R. Stimson, M.D., president

Maurice E. Glock, M.D., president-elect
John M. Paris, M.D., chairman of the Council
Don E. Wood, M.D.
Irvin W. Wilkens, M.D., treasurer
James A. Waggener, executive secretary

By ballot, Dr. Don E. Wood was re-elected chairman of the Executive Committee.

There being no further business the Committee adjourned to meet again on Saturday, November 18, 1961.

THE COUNCIL

Indianapolis
Oct. 23, 1961

The Council convened at 3:00 p.m., Eastern Standard Time, in Parlors B and C of the Columbia Club, Indianapolis, on October 23, 1961, with Dr. Maurice E. Glock, chairman, presiding. Roll call showed the following present:

Councilors:

First District—William B. Challman, Mount Vernon.
Second District—Edward T. Edwards, Vincennes.
Third District—John M. Paris, New Albany.
Fourth District—Joe M. Black, Seymour.

Fifth District—V. Earle Wiseman, Greencastle. A. W. Cavins, Terre Haute, alternate (also associate editor, *The Journal*)

Sixth District—William R. Tindall, Shelbyville, alternate.

Seventh District—Ralph V. Everly, Indianapolis.

Eighth District—Gordon B. Wilder, Anderson.

Ninth District—Kenneth O. Neumann, Lafayette.

Tenth District—Ralph C. Eades, Valparaiso, alternate.

Eleventh District—E. S. Rifner, Van Buren.

Twelfth District—Maurice E. Glock, Fort Wayne.

Milton F. Popp, Fort Wayne, alternate.

Thirteenth District—Burton E. Kintner, Elkhart.

Officers:

Guy A. Owsley, Hartford City, president.

Harry R. Stimson, Gary, President-elect.

Irvin W. Wilkens, Indianapolis, treasurer.

Journal:

Frank B. Ramsey, Indianapolis, editor.

Executive Committee:

Don E. Wood, Indianapolis, chairman (also co-chairman, Commission on Legislation).

Wendell E. Covalt, Muncie, member.

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate.

E. S. Jones, Hammond, AMA delegate.

Gordon B. Wilder, Anderson, AMA delegate.

Wendell C. Stover, Boonville, AMA delegate.

Walter L. Portteus, Franklin, AMA alternate delegate.

John M. Paris, New Albany, AMA alternate delegate.

Philip B. Reed, Indianapolis, chairman, Grievance Committee.

John D. VanNuys, Indianapolis, dean, I. U. School of Medicine.

A. C. Offutt, Indianapolis, State Health Commissioner.

James O. Ritchey, Indianapolis, acting chairman, Student Loan Committee.

James M. Leffel, Indianapolis, chairman, Commission on Convention Arrangements.

L. L. Pickering, Fort Wayne, Executive Secretary, Fort Wayne Medical Society.

A. P. Tiernan, Evansville, Executive Secretary, Vanderburgh County Medical Society.

Staff:

Howard Grindstaff, field secretary.

J. A. Waggener, executive secretary.

On motion of Dr. Paris, seconded by many, minutes of the July 9, 1961, Council meeting were approved as printed in the September, 1961, issue of *The Journal*.

On motion of Drs. Challman and Eades the Council voted to send a telegram to Dr. James P. Vye who was unable to be present because of illness.

Reports of Officers

DR. GUY A. OWSLEY, President: Mr. Chairman, I want to take this opportunity to thank all of the Councilors and members of the Executive Committee and the staff for their cooperation during this last year. I would be the first to say that this has not been a perfect year in the administration of our State Association, but I would also say that most of us have tried. Maybe, as someone has said, our sights have been too high, but I want to call your attention again to two matters of participation which are included in my last page of *The Journal* this month concerning the I-Hope Committee and the Building. Someone surely can do a better job in each of these instances. We have only had approximately a sixth or seventh of the dues paying members of the Association contribute to I-Hope and we have only had approximately 50% contribute to the building. These are both matters of intense interest to the future of our Association and I hope all of your Councilors will go back to your Districts and make every effort possible to see to it that there is wider participation in this area. I know that you've tried up till now but we're just going to have to push a little harder.

Again I want to thank all of you. We're going to have I feel a grand Convention. The program committee has gone all out and I urge everybody to attend the scientific sessions. Thank you very much.

DR. HARRY R. STIMSON, President-elect: I do

not wish to make a report at this time, but I think that even though Dr. Owsley will have several ovations during this convention, I think this smaller body should give him a standing ovation for the work he has done in the past year. I would like to see you do that. (Applause.)

DR. IRVIN W. WILKENS, Treasurer, reported that the auditor's statement showed that the Association is in good financial condition, with a total in cash and securities of \$201,713.63. To date \$80,608.50 has been spent on the new headquarters building, covering the land, wrecking of a building, legal fees, architects fees, insurance and miscellaneous expenses.

Dr. Wilkens asked for an expression from the Council on whether the securities now held by the Association should be used to pay the balance due the building contractor, or whether the Association should borrow money to pay this bill, inasmuch as the revenue to be derived at maturity on the securities would be more than it would cost to borrow money from the bank.

(On motion of Dr. Challman, seconded by many, the Council voted to appoint a committee to investigate the rates at which it is possible to borrow money, this committee to report to the January Council meeting.)

DR. FRANK B. RAMSEY, editor of *The Journal*: The figures that are published in the Delegates Handbook are a year old and we have just now completed another year in addition to those. We were a little behind financially a year ago and right now we're a little more behind. We haven't gotten to the place yet where we've had to borrow any money or go into the red but this year just closed we spent more than we took in.

We have lived within the budget which we have decided upon almost exactly except for one thing and that was on the income that we expected to get from advertising. This has fallen off enough so that we are short for the year, excess of outgo over income by about the amount of money which we missed on anticipating the advertising revenue.

This shows a little sign of getting better. Already some of the orders that we have suffered on in the past have begun to pick up. So I think we can look ahead to the time when advertising is going to be a little better.

There is a tendency in the pharmaceutical business, which is, of course, our main advertising item, for them to obligate their advertising to State Medical Journals in particular for an entire year, ahead of time and announce what their obligation is going to be. This will help tremendously because it gives us some idea of what to expect. Up till now they have frequently changed their advertising budget from month to month and we never knew ahead of time, even one month ahead of time. This next year some of the larger ones are going to announce ahead of time how many pages they're going to take and then stick to it.

I might say that I don't believe *The Journal* has ever been any better off since I've been editor except for this financial flurry. We're getting plenty of nice papers. This comes at a time when it's a little ironic we're not able to publish as many papers. But we're getting

more than we did when we could publish a lot. They have all been good papers and I'm trying to accept as many good ones as I can and ask the authors to wait a little longer to have them published. Some of the members of the Council have been very cooperative about writing social economic special articles for us. The whole thing is working out better, except for the matter of money I think we're way ahead.

District Meetings

District meetings were reported scheduled as follows for 1962:

First District—Not set.

Second District—Not set.

Third District—New Albany, May 16, 1962.

Fourth District—Bateville, May 2 or 16, 1962.

Fifth District—Terre Haute, —, 1962.

Sixth District—Connersville, May 10, 1962.

Seventh District—Not set.

Eighth District—, June 13, 1962.

Ninth District—Noblesville, May 17, 1962.

Ten District—Not set.

Eleventh District—, May 16, 1962.

Twelfth District—Fort Wayne, —.

Thirteenth District—Not set.

Unfinished Business

1. *Convention Arrangements.* Dr. James M. Leffel, chairman, thanked the officers, councilors, Executive Committee, and headquarters staff for their assistance on convention arrangements and asked that everyone encourage the membership to attend the scientific sessions at which time some of the finest talent obtainable will appear.

2. *Student Loan Fund.* Dr. J. O. Ritchey, acting chairman, spoke of the need for additional funds if the Student Loan Committee is to continue to grant loans to all worthy applicants.

The chairman read the following letter which he had received from Dr. Ritchey:

The Student Loan Committee of the Indiana State Medical Association would, at this time, like to request an appropriation of \$10,000 from the general operating funds of the Association for a continuation of the Committee's activity in granting loans to deserving students of the Indiana University School of Medicine.

The Committee, at its last meeting on October 4, granted four more loans, representing extreme hardship cases, for a total of \$1,400.00, leaving a balance in the fund of \$139.46.

At this meeting a total of 12 students were interviewed, but it was necessary that the application of 8 be held in abeyance and in the majority of instances this action was necessary because of the lack of funds.

We should explain to the Council that, due to a continuing program of follow-up, several physicians now in practice or in advanced training have been in contact with the Committee indicating that repayment of loans, including interest, will soon be forthcoming. This policy of collection efforts will be pursued vigorously, I might add.

However, it is not anticipated by the Committee that loan repayment will be in sufficient quantity to enable

the Committee to act with any degree of proficiency and thus it was the unanimous opinion that a request for additional funds should be made of the Council.

While the report of the Committee was fully published in the convention issue of *The Journal*, we should add that the Committee—inclusive of loans granted at its last meeting—has now extended aid to 94 students, representing total expenditure of \$48,258.36. Payments on notes and interest collection have amounted to \$7,885.82.

Turning to another matter, the Committee had considerable discussion at its last meeting concerning the program of the United Student Aid Funds, Inc.

The Committee is cognizant of the fact that at the Council meeting of last July 9 opinion was expressed that it probably would not be appropriate for the Indiana State Medical Association to contribute to this organization which, as you know, embraces a far-reaching program of aid to deserving students in many fields of endeavor.

However, during the Committee's discussions at its recent meeting, these points were brought to the fore:

1. That 16% of loans granted by the United Student Aid Funds were made to medical students;
2. That supporters of the funds are persons of leadership and influence whose good will is a valuable asset to the medical profession;
3. That from a standpoint of good public relations it might be well if the Council of the Indiana State Medical Association would consider making a token donation to the SAF, such donation to be within the limitations of funds the Council might feel were available for the purpose.

In behalf of the Committee, and in behalf of the many students who have benefited in such a remarkable way from the program, thank you for your consideration to these matters.

Following discussion by Drs. Paris, Wilkens, Wilder, Challman, VanNuys, Kintner and Rifner, **on motion of Drs. Paris and Eades the Council voted to ask for further study of this matter and to submit the following request to the House of Delegates:**

That the Council request the permission of the House of Delegates to give to the Higher Education Loan Plan the sum of \$2,000, to be taken from the present reserves of the Association for the purpose of permitting banks of this state to loan 12½ times this amount to students in our schools of higher education.

3. *Building Committee.* Dr. Everly, chairman, presented a report from the Building Committee. (See pages 1888, December *Journal*, for full report.)

The following resolution, presented by Dr. Everly, **was approved on motion of Drs. Paris and Neumann:**

WHEREAS a construction contract for the Headquarters Building was entered into under date of August 29, 1961, and which contract provides for the execution of certain instruments and papers in connection therewith, such as change orders, and

WHEREAS such instruments and papers need to be executed promptly in the expediting of the construction of said building;

BE IT RESOLVED, that the Chairman of the

Building Committee, or the Vice-chairman of said Committee, be authorized to approve and execute all instruments and papers required or authorized to be executed or approved by the Indiana State Medical Association under the terms of said construction contract, such instruments and papers to be attested to by the Executive Secretary.

Dr. Everly presented the following resolution **which was approved on motion of Drs. Paris and Stimson:**

WHEREAS a construction contract for the Headquarters Building was entered into under date of August 29, 1961, and

WHEREAS carpeting and paving of the drive and parking lot were deleted from said contract, and furnishings were not included in the said contract;

NOW BE IT RESOLVED that the Building Committee be, and it now is, authorized to enter into contract for said carpeting and furnishings and to do all things needed to complete said building and make the same ready for occupancy; and

BE IT FURTHER RESOLVED that the Building Committee be, and it is authorized, to receive bids for paving the drive and parking lot and to let a contract therefor to the bidder who, in its judgment, submits the lowest and best bid therefor, providing that the letting of such contract does not cause the total cost to exceed the sum of four hundred thousand dollars (\$400,000.00).

On motion of Dr. Challman, seconded by many, the Council approved the expenditure of \$2,000.00 to create an outlet onto 40th Street from the rear of the headquarters lot.

4. *Liaison Committee between Council and Blue Shield.* Dr. Challman reported that the meeting with Blue Shield was held on August 23, at which time the reconfirmation procedure with Blue Cross was the principal topic of discussion. "We didn't come to any definite agreement, principally I think, because the Executive people of Blue Cross felt that they were bound by their Board of Directors' action. However, they did pencil out a shorter form which they said they would use in the future and I think they have been sending them to the hospitals and I have a copy which I'll pass out. In some of the hospitals the executive staff has been doing most of the work and all you have to do is check it yes or no and sign it. . . . I still think it's basically wrong but it appears that that was the best we could do at that time."

Dr. Edwards read the following resolution from the Blue Shield Liaison Committee, which had been endorsed at the last meeting of the Executive Committee of Blue Shield, the purposes of which are:

- (1) To get some recognition of the fact that doctors alone cannot reverse the continuing increase in total medical care costs—that hospitals have to do some work of their own, and
- (2) That insurance contracts are not written to cover the practice of medicine and many times have forced a change in the concept of the practice of medicine, forcing physicians to use the most expensive facilities and methods of providing good health care.

Resolution No. 17

Resolution No. 17:

Subject: RESOLUTION PROPOSING JOINT
STUDY OF MEDICAL CARE
COSTS

WHEREAS, it behooves the medical profession in all Indiana communities to have an awareness of the economics of medical care and to exert leadership in its own as well as related fields in regards to modern-day financing in the area of health services; and

WHEREAS, such services must be tendered at the lowest possible figure consistent with the best quality of care and in keeping with economic factors attendant upon the purveyors of health services; and

WHEREAS, influences relating to the economics of modern medical care revolve not only upon the medical profession but upon hospitals, health insurance indemnifiers, underwriters, patients and others; and

WHEREAS, because of the many complexities involved in arriving at a reliable and complete analysis of the economics related to today's disbursements for all health services; now

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association, through initiation by its properly designated officials, assume leadership in establishment of a Joint Committee on the Economics of Modern Health Services; and

BE IT FURTHER RESOLVED that the following groups be invited to join with the Indiana State Medical Association in committee membership:

Blue Cross of Indiana, Blue Shield of Indiana, Indiana Hospital Association, Indiana Health Insurance Council and that each of the said groups, including the State Medical Association, name three representatives to membership on the committee; and

BE IT FURTHER RESOLVED that such committee will launch research studies related to the economics of modern-day medical care, develop suggestions and recommendations pertinent to the total involvement and undertake adoption of such recommendations by each participating group.

Following discussion by Drs. Edwards, Stimson, Paris and Neumann, on motion duly made and seconded, the Council voted to present Resolution No. 17 to the House of Delegates.

5. *Osteopathic matters.* Drs. Jones, Ochsner and Stover discussed the AMA's action on osteopathy which "left it up to local option and ruled that an osteopath can be recognized only if he practices scientific medicine. Also, the Joint Commission on Accreditation of Hospitals now approves recognition of hospitals with osteopaths on the staff."

The chairman read a communication from the AMA, addressed to a county medical society secretary in Indiana, in reply to the secretary's request for clarification of policy regarding relationships between doctors of medicine and doctors of osteopathy, which stated:

"It is the obligation of the State Medical Association to apply this policy at state level, according to facts as they exist. Therefore, the final answer to your question must come from the Indiana State Medical Association."

Discussed by Drs. Owsley, Kintner, and others. On motion of Drs. Kintner and Edwards, the Council voted to submit the following statement of policy from the Council to the House of Delegates for reaffirmation by the House:

Mr. President, members of the House: Inasmuch as it has been the policy of this Association to adopt the principles of medical ethics of the AMA as the principles of ethics of the Indiana State Medical Association, and inasmuch as the House of Delegates of the AMA took action in June to enunciate a new policy as same refers to relationships between doctors of medicine and doctors of osteopathy, the Council recommends we reaffirm our policy of accepting the ethics of the AMA as ethics of the ISMA on this subject. The AMA statement is as follows:

"Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

6. *Election of two members to Editorial Board.* On motion of Drs. Challman and Stimson, Drs. Harold D. Lynch, Evansville, and Jene R. Bennett, South Bend, were re-elected members of the Editorial Board, each for a three-year term ending December 31, 1964.

7. *Nominations for Blue Shield Board members.* On motion of Dr. Eades, Dr. William Harry Howard was nominated for re-election to the Blue Shield Board of Directors as a member at large, for a three-year term ending March, 1965.

The Council confirmed the following district nominations for membership on the Board of Directors of Blue Shield for the three-year term expiring March, 1965:

Representing

District 9—R. R. Calvert (Vice President), Lafayette
District 1—George W. Willison, Evansville
District 8—Fletcher W. McDowell, Muncie
District 12—Mahlon F. Miller, Fort Wayne
District 5—H. T. Goodman, Terre Haute

Legislative Matters

Dr. Don E. Wood, co-chairman of the Commission on Legislation, discussed local and national legislative problems and stressed the need of help at the local level on all of these matters.

On motion of Drs. Black and Stimson the Council went on record commending Dr. Wood for his fine presentation on the King-Anderson Bill, H. R. 4222, before the House Ways and Means Committee in Washington

Membership Matters

Remission of state dues. On motion of Drs. Wiseman and Black, remission of the state dues of a member of the Clay County Medical Society, due to illness and hardship, was approved.

New Business

1. *Matters referred to Council by Executive Committee.*

a. *Insurance to cover ISMA and members of county society grievance committees.* The following matter, received by the Executive Committee, was referred to the Council, and **on motion duly made and seconded, the Council voted to refer it to the House of Delegates:**

"Meeting, September 17, 1961—Grievance Committee—Doctor Topping made the motion that the Grievance Committee should ask the Executive Committee to check into a blanket insurance policy which is available to cover the Indiana State Medical Association and members of the county medical societies who are serving on local grievance committees."

b. *Resolution on Medical Ethics.* On motion duly made, seconded by Dr. Challman, the Council voted to refer the following resolution, which was received from Allen County, to the House of Delegates:

"WHEREAS, the House of Delegates of the American Medical Association, with the advice of the Council on Medical Service and the opinion of the Judicial Council, did pass resolutions concerning principles of Medical Ethics at the June Annual Meeting; and

WHEREAS, the American College of surgeons has by public pronouncement indicated that the American College of Surgeons should establish standards of conduct for the entire profession; and authority which has not been delegated by the American Medical Association; and

WHEREAS, this action is at a time when the medical profession should be united and not disrupted by schisms between groups; now therefore

BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association 1) reaffirm the approval of the House of Delegates of the American Medical Association concerning the principles of medical ethics, and 2) censor the American College of Surgeons for their action taken at their meeting in Chicago in October, 1961."

c. *Resolution on Blue Shield.* The following resolution, referred without action by the Executive Committee to the Council, was discussed by Drs. Stimson, Neumann, Challman, Kintner and Edwards, and **on motion duly made and seconded, it was referred to the House of Delegates:**

RESOLVED, That the Indiana State Medical Association recommend and encourage Blue Shield to offer to the Public of Indiana, a payment plan for medical care, similar to Medicare, which plan will have no schedule of indemnities; but Blue Shield will pay the regular charges made by physicians in the areas in which the services are rendered, and that the County Medical Societies and the Indiana State Medical Association be urged to establish advisory committees for the purpose of assisting Blue Shield in developing such

a plan, and generally assisting Blue Shield in the operation of the plan.

d. *Better Business Bureau membership for 1962.* On motion duly made and seconded, the Council authorized the payment of a \$150.00 membership in the Better Business Bureau for 1962.

e. *Resolution No. 8.* Dr. Wood asked the Council to support this resolution complimenting Dr. Otis Bowen for his services in the State Legislature.

2. *Grievance Committee.* Dr. Philip Reed, chairman, reported on the study of medical discipline in Indiana, as approved by the reference committee in 1960, and read the actions taken by the Grievance Committee and the group which met with that committee on September 17, 1961, as follows: (for complete report see pages 1876, December, 1961, *The Journal*)

"The June 1961 Conclusions and Recommendations (Section XI) of the AMA Medical Disciplinary Committee as passed by the AMA House of Delegates was approved with the following exceptions:

Page 68, Section (f)—the word "primary" should be changed to "important."

Page 71, Section (i)—Review and utilization committees should be set up by hospital medical staffs instead of state medical associations.

Page 72—It was the consensus that sections (g) and (i) should be disapproved.

In reply to the question, "Does the State Grievance Committee have more authority now than it had prior to the AMA meeting?" Dr. Reed answered:

"I don't believe it has more authority. I think that it has received several worthwhile suggestions that we believe will actually give the county medical societies a little better basis for procedure. I don't want to take too much time and I'll illustrate with only one. Those of you who have read the conclusions and recommendations will note that the grievance committee, or a kindred group in the county society that does not have a grievance committee, acts as a grand jury in investigating certain cases. This of course would take the heat off of one individual in a county medical society or on a committee. And this, of course, was part of Dr. Topping's thinking in the action that was referred to the Executive Committee. We feel it would be exorbitantly expensive to protect an entire membership of a county medical society, or the state association, but it is not expensive, according to Dr. Topping who has gone into it, to provide insurance to protect these men who are acting in behalf of organized medicine in a county on a grievance committee or on a state grievance committee against suit. The grand jury step I think will further minimize this risk.

"As you can see from the tenor of our action, we are desirous of preserving and, if anything, strengthening the county medical society's hand rather than passing this to the AMA."

Dr. Reed's report was accepted by consent.

3. *Dr. John D. VanNuys, Dean, I. U. School of Medicine,* reported briefly on medical school affairs.

4. *Dr. A. C. Offutt, State Health Commissioner,* called attention of the Council to the intensive study of the problem of radioactivity of atomic fallout material which is being conducted by the State Board of Health.

"We have had meetings with the milk industry first; secondly we've asked some pediatricians to meet with us. And we expect at a later time to discuss the problem with some of the radiologists, and others. . . . We have asked for, and the Governor has approved the purchase of a machine, an instrument for measuring the micro-microcuries of fallout of several of the elements, at a cost of about \$23,300."

5. *Election of JOURNAL editors.*

a. *Editor.* **On motion duly made and seconded, Dr. Frank B. Ramsey, present Editor of THE JOURNAL, was re-elected editor for 1962.**

b. *Associate Editors.* **On motion duly made and seconded, the following present associate editors of THE JOURNAL were re-elected for 1962:**

A. C. Cavins, Terre Haute
Lall G. Montgomery, Muncie
David A. Bickel, South Bend
Stephen L. Johnson, Evansville

6. *Resolutions to be introduced in the House of Delegates* were read by title and discussed.

7. *AMA Support by Individual Physicians.* **By consent the Council voted to refer the following resolution to the House of Delegates without recommendation:**

Inasmuch as numerous efforts by certain political opponents of the American Medical Association have been made in recent months in the press and other media to discredit the American Medical Association by insinuating (or by stating outright) that the Association does not have the support of the majority of practicing physicians in this country and does not represent the will of the majority of practicing physicians in this country,

BE IT RESOLVED, that the various county medical societies of the Indiana State Medical Association go on public record (by paid advertisement, if necessary) as stating emphatically that the American Medical Association does, indeed, represent their will and desire and that the present leadership of the American Medical Association enjoys the full confidence and support of the en-

tire membership of the Indiana State Medical Association;

BE IT FURTHER RESOLVED, that other state medical associations be encouraged to do likewise in an effort to squelch, at least, this bit of misinformation currently circulating through the mass media

8. *Dr. Kintner presented the following resolution for the Council's sponsorship:*

WHEREAS the Woman's Auxiliary of the Indiana State Medical Association has established itself as an organized and capable body, and

WHEREAS it was established for many purposes, including aid to the ISMA . . . many medical activities, and

WHEREAS the efficiency which the Auxiliary has shown in carrying out its assigned task has resulted in greater accomplishments in these areas,

BE IT THEREFORE RESOLVED that the Auxiliary of the ISMA be requested to study with its advisors, Don Wood, et al., ways and means by which it may aid increased attendance of members of the ISMA to the annual convention, and

BE IT FURTHER RESOLVED that the Woman's Auxiliary of the ISMA consider the advantages and disadvantages of holding its annual convention the same date and place as the ISMA as a possible aid to ISMA to increase attendance of its members. After this study has been made it is requested that the Woman's Auxiliary report be given to the appropriate Commission of the ISMA for conclusive study and recommendation for advisory action by the 1962 House of Delegates meeting.

On a standing vote the Council tabled the above resolution.

January Meeting

On motion of Drs. Black and Edwards, the next meeting of the Council will be held on January 14, 1962.

There being no further business, the Council adjourned to meet again on Thursday, October 26, 1961, in the Columbia Club, Indianapolis, immediately following adjournment of the House of Delegates.

THE COUNCIL

October 26, 1961

The Council met for its second meeting immediately following adjournment of the House of Delegates, Thursday afternoon, October 26, 1961, in the Harrison Room of the Columbia Club, Indianapolis.

Ten councilors, three alternate councilors, the president, president-elect and the executive secretary were present.

Elections for 1961-62

1. *Chairman of Council.* By ballot, Dr. John M. Paris, New Albany, was elected chairman of the Council for 1961-62.

2. *Executive Committee.* Upon motion of Drs. Everly and Kintner, Dr. Don E. Wood, Indianapolis, and Dr. Wendell E. Covalt, Muncie, were re-elected members of the Executive Committee for 1961-62.

There being no further business, the meeting was adjourned.

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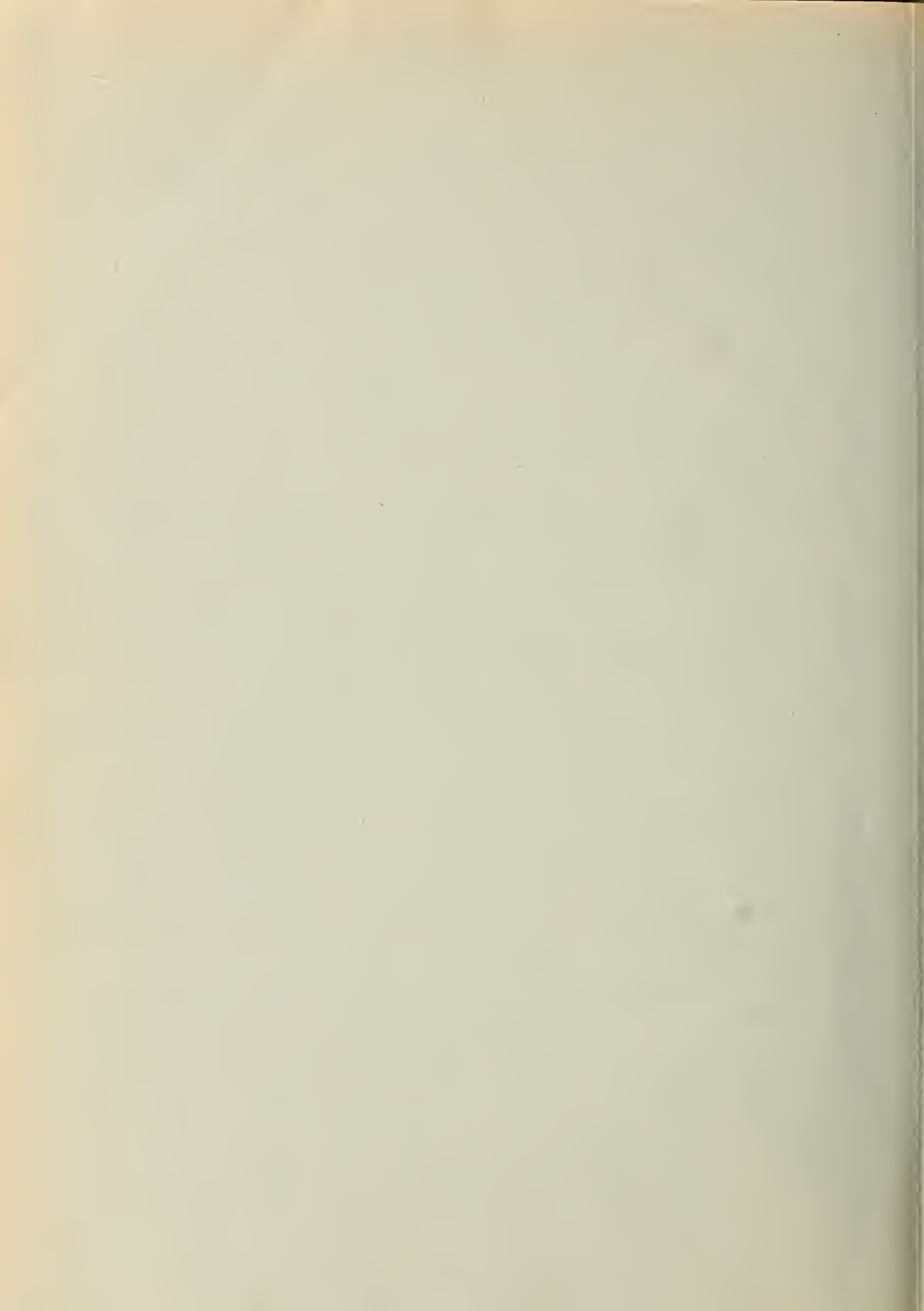
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